

12623

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G235 11-17-58 et

## CERTIFICATE OF DEATH

12598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>Knoxville</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ollice</b> Middle <b>Lucille</b> Last <b>Akard</b>				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 7, 1906</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>58</b>		IF UNDER 24 HRS. Days <b>5</b> Hours <b>19</b> Min. <b>58</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert N. Caldwell</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Simms</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>415-50-7493</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Parathyroid Adenoma</b> DUE TO (c) <b>493X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493X</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>September 25, 1958</b> to <b>November 5, 1958</b> that I last saw the deceased alive on <b>November 5, 1958</b> and that death occurred at <b>8:15 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leon I. Goldberg</b> M.D.				DATE SIGNED <b>11-6-58</b>			
PHYSICIAN'S NAME (Type) <b>Leon I. Goldberg, M.D.</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>11/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lynhurst Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Knoxville, Tennessee</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be filed with the funeral director, the funeral director, and the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>33 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6812 Florida St.</u>			e. STREET ADDRESS <u>6812 Florida St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>F</u> Last <u>Alfaro</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-88</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Spain</u>	
13. FATHER'S NAME <u>Ramon Alfaro</u>			14. MOTHER'S MAIDEN NAME <u>Guadalupe Guastavino</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruth M. Alfaro</u> Address <u>Ramon Alfaro 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11-26-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Clinton, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S. H. Hines Co. Washington, D. C.</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

WEST VIRGINIA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Age: \_\_\_\_\_

3. Sex: \_\_\_\_\_

4. Race: \_\_\_\_\_

5. Date of Birth: \_\_\_\_\_

6. Date of Death: \_\_\_\_\_

7. Place of Death: \_\_\_\_\_

8. Cause of Death: \_\_\_\_\_

9. Manner of Death: \_\_\_\_\_

10. Signature of Examiner: \_\_\_\_\_

11. Signature of Coroner: \_\_\_\_\_

12. Signature of Physician: \_\_\_\_\_

13. Signature of Medical Examiner: \_\_\_\_\_

14. Signature of Medical Examiner: \_\_\_\_\_

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12625

CERTIFICATE OF DEATH

Reg. Dist. No.

12600

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6711 Georgia Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Aubrey</u> Last <u>Allan</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N. E. A. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Johns, New Brunswick USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William C Allan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Aubrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-42-2720</u>	
17. INFORMANT <u>Mrs Izora S. Allan-Item#2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>essential hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4</u> , 19 <u>58</u> , to <u>Nov 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>58</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7852 16<sup>th</sup> St. NW</u> DATE SIGNED <u>11/3/58</u> ACTUAL SIGNATURE <u>H. F. Kreuzburg</u> M.D. <u>Wash DC</u> PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12626

## CERTIFICATE OF DEATH

12601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>		d. STREET ADDRESS <u>3248 Patterson St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Bettie D.</u>		4. DATE OF DEATH <u>Nov. 16 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1861</u> 96 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fayette De Val</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss Ruth Amiss</u> Address <u>2006-5502</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis, advanced</u> DUE TO (c) <u>Arteriosclerosis, generalized</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>5 yrs +</u> <u>10 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Occlusion August 1958</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not-while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 15</u> , 19 <u>58</u> , to <u>Nov 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>58</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash 15 D.C.</u> DATE SIGNED <u>Nov 16 58</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>Nov 18 58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12627

## CERTIFICATE OF DEATH

12602

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9601 COLESVILLE Rd.</b>		d. STREET ADDRESS <b>19601 COLESVILLE Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>ANN</b> Last <b>ANDREWS</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 15, 1864</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years last birthday) yrs <b>94</b>
11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jules Etienne Dietsch</b>		14. MOTHER'S MAIDEN NAME <b>Elise Vuillamier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>son, John N. Andrews</b>		Address <b>M D</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senile myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Old age</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. j. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>35</b> , to <b>Nov. 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 17</b> , 19 <b>58</b> , and that death occurred at <b>8:35 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John N. Andrews</b>		ADDRESS (Street, city or town, state) <b>9601 Colesville Rd Silver Spring Md</b>	
DATE SIGNED <b>11-17-58</b>			
PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Nov 18, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John N. Andrews</b>		ADDRESS <b>254 Carroll St NW</b>	
24a. REC'D BY REGISTRAR <b>NOV 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



CERTIFICATE OF DEATH

1911

Name of Deceased		Age		Sex		Race	
John A. Smith		45		Male		White	
Residence		Date of Death		Time of Death		Place of Death	
123 Main St., Boston		Jan 15, 1911		10:30 AM		Home	
Cause of Death		Disease		Duration		Manner of Death	
Myocardial Infarction		Coronary Artery Disease		2 weeks		Natural	
Medical History		Previous Illnesses		Occupation		Social History	
Hypertension		Angina Pectoris		Carpenter		Sobriety	
Treatment		Physician		Hospital		Burial	
Digitalis		Dr. J. B. Brown		St. Mary's		Catholic	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased	
J. B. Brown		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Official Seal		Remarks	
Jan 16, 1911		Boston		[Seal]		[Remarks]	

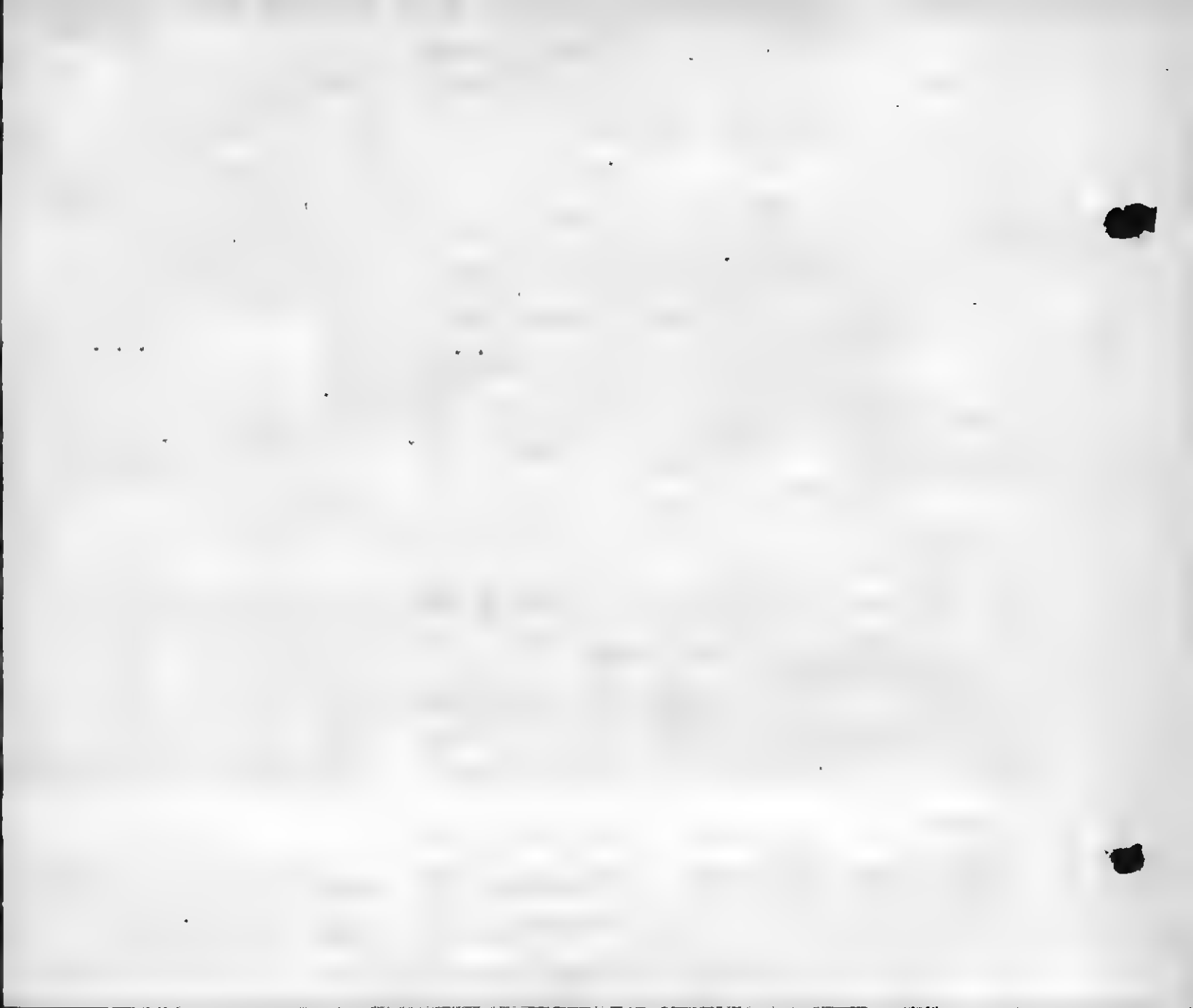
12598 Item 2 Film 5746 12-4-58 et  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

12603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK MD</b>		c. LENGTH OF STAY IN 1b <b>4 MO.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>OAK HAVEN REST HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY E</b> Middle <b>AULT.</b> Last		4. DATE OF DEATH Month <b>11/27/58</b> Day <b>19</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN KING</b>	
14. MOTHER'S MAIDEN NAME <b>MARY E KING.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>EDMOND AULT.</b> Address <b>WHEATON MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial failure</b> 4/27/58 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>advanced cerebral arteriosclerosis - 5 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 5, 1958</b> to <b>Nov 27, 1958</b> , that I last saw the deceased alive on <b>Nov 27, 1958</b> , and that death occurred at <b>11:04 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel B. Washington</b> M.D.		DATE SIGNED <b>11/27/58</b>	
PHYSICIAN'S NAME (Type) <b>Daniel B. Washington MD</b>		ADDRESS (Street, city or town, state) <b>6234 Ga. Ave NW Wash. DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/29/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST JOHNS CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>FOREST GLEN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Thompson</b>		24a. REC'D BY REGISTRAR <b>11/27/58</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. S. Fisher</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12604

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN It <u>27m</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5401 Cromwell Dr.</u>		f. STREET ADDRESS <u>Cromwell Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Clara</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-92</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>	
11. BIRTHPLACE (State or foreign country) <u>DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Bernheimer</u>		14. MOTHER'S MAIDEN NAME <u>Bernie Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>578-48-0589</u>	
17. INFORMANT <u>Bernard H. Conn</u>		Address <u>Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>11/2/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASH. HEBREW</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawicki Sons 1736 Penna. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 show forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.





12629

CERTIFICATE OF DEATH

12605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4700 West Virginia Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie C. Baxter</u>				4. DATE OF DEATH Month Day Year <u>Nov 30 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/87</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months Days Hours Min. <u>1 24</u>	IF UNDER 24 HRS Hours Min. <u>24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>? Baxter</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Lena Broadhurst-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>330x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paralytic Ileus</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 Days</u> <u>48 hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralytic Ileus</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 19, 1958</u> , to <u>Nov 30, 1958</u> , that I last saw the deceased alive on <u>Nov 30, 1958</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.				ADDRESS (Street, city or town, state) <u>10511 Summit Ave</u>			
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>				DATE SIGNED <u>12-1-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12630

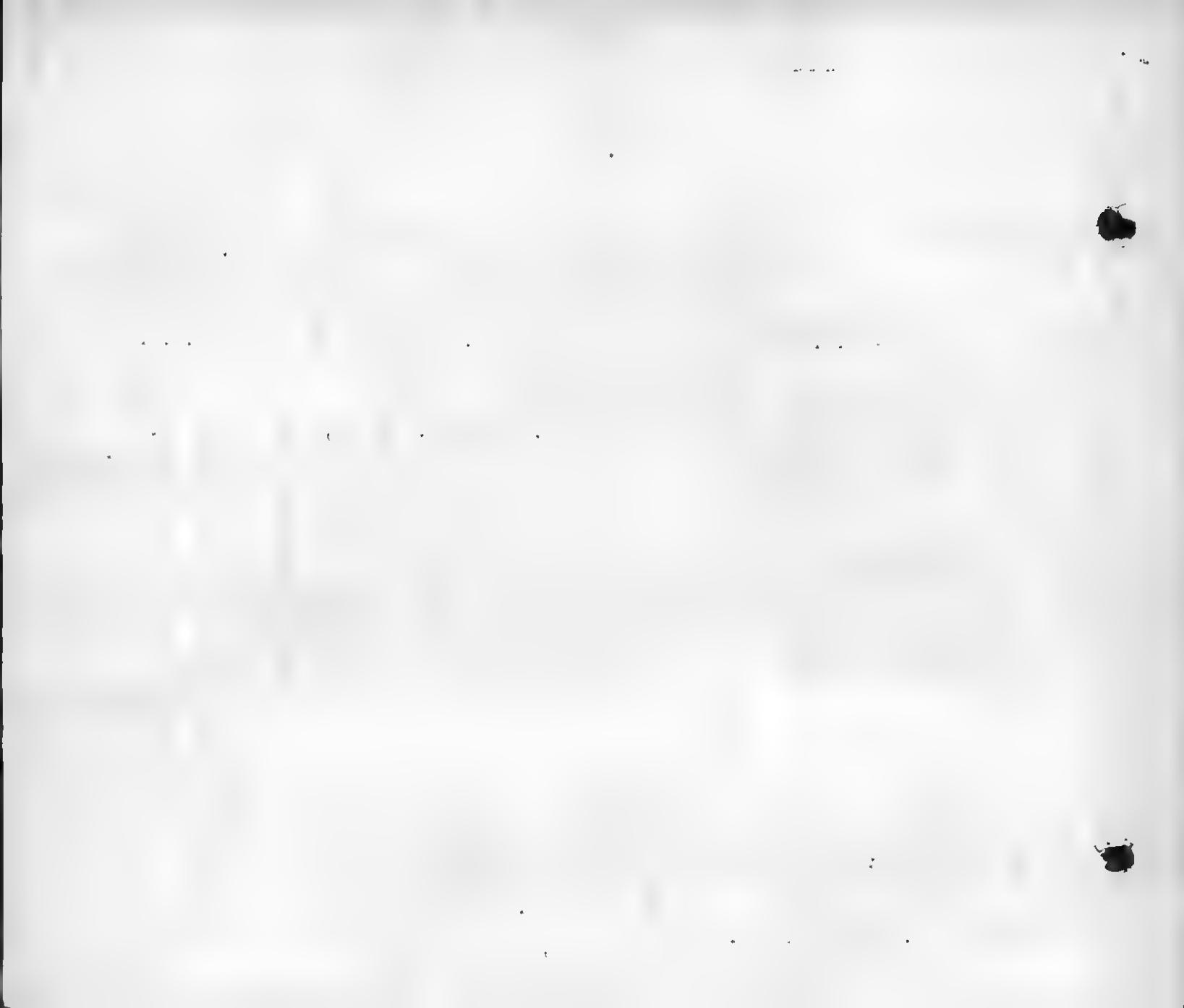
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 729 EASLEY STREET				d. STREET ADDRESS 729 EASLEY STREET			
3 NAME OF DECEASED (Type or print) First VICTOR Middle HUGO Last BENDER				4. DATE OF DEATH Month NOV. Day 20 Year 19 58			
5. SEX MALE		6 COLOR OR RACE WHITE		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 5/11/96	
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR - D.C. Property Yards				10b. KIND OF BUSINESS OR INDUSTRY ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME RUDOLPH BENDER				14 MOTHER'S MAIDEN NAME IDA FISCHER			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16 SOCIAL SECURITY NO. none		17 INFORMANT Mrs. Hallie G. Bender, 729 Easley St. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1/22</u> 19 <u>53</u> , to <u>11/20</u> 19 <u>58</u> that I last saw the deceased alive on <u>11/18</u> 19 <u>58</u> , and that death occurred at <u>3:10 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. Luther Hall</u> M.D. <u>1150 Coma Ave.</u> <u>11/20/58</u> PHYSICIAN'S NAME (Type) <u>W. Luther Hall</u> <u>Wash. G. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/24/58		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WATER E. PUMPHREY, INC. <u>Raymond A. Ziska</u>				ADDRESS SILVER SPRING, MARYLAND		24a REC'D BY REGISTRAR DATE NOV 24 '58	
				24b. REGISTRAR'S SIGNATURE <u>Clifton E. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. The funeral director should be notified by the funeral director, and page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film G-1-5 12/4/58 car

12631

## CERTIFICATE OF DEATH

12607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>7660 Canoga Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Daniel D. W. Blaylock</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 28, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>15</u> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mining Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (State & foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Blaylock</u>				14. MOTHER'S MAIDEN NAME <u>Meyers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>322-07-8239</u>			
17. INFORMANT <u>Wife</u> Address <u>Mary Blaylock - Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Glomerulonephritis</u> DUE TO (c) <u>Chronic Glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>Weeks, years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Infection Left Internal Capsule</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 4, 1958</u> to <u>NOV 25, 1958</u> , that I last saw the deceased alive on <u>11-25-1958</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. Tilley, Jr.</u>				DATE SIGNED <u>11-25-58</u>			
PHYSICIAN'S NAME (Type) <u>R. M. Tilley</u>				ADDRESS (Street, city or town, state) <u>4701 Mass. Ave. n.w. Wash. 16 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL, ISOTHERM		22b. DATE THEREOF <u>11/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marissa</u>		22d. LOCATION (City, town, or county) (State) <u>Marissa, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Howard</u>	

MEDICAL CERTIFICATION





12632

## CERTIFICATE OF DEATH

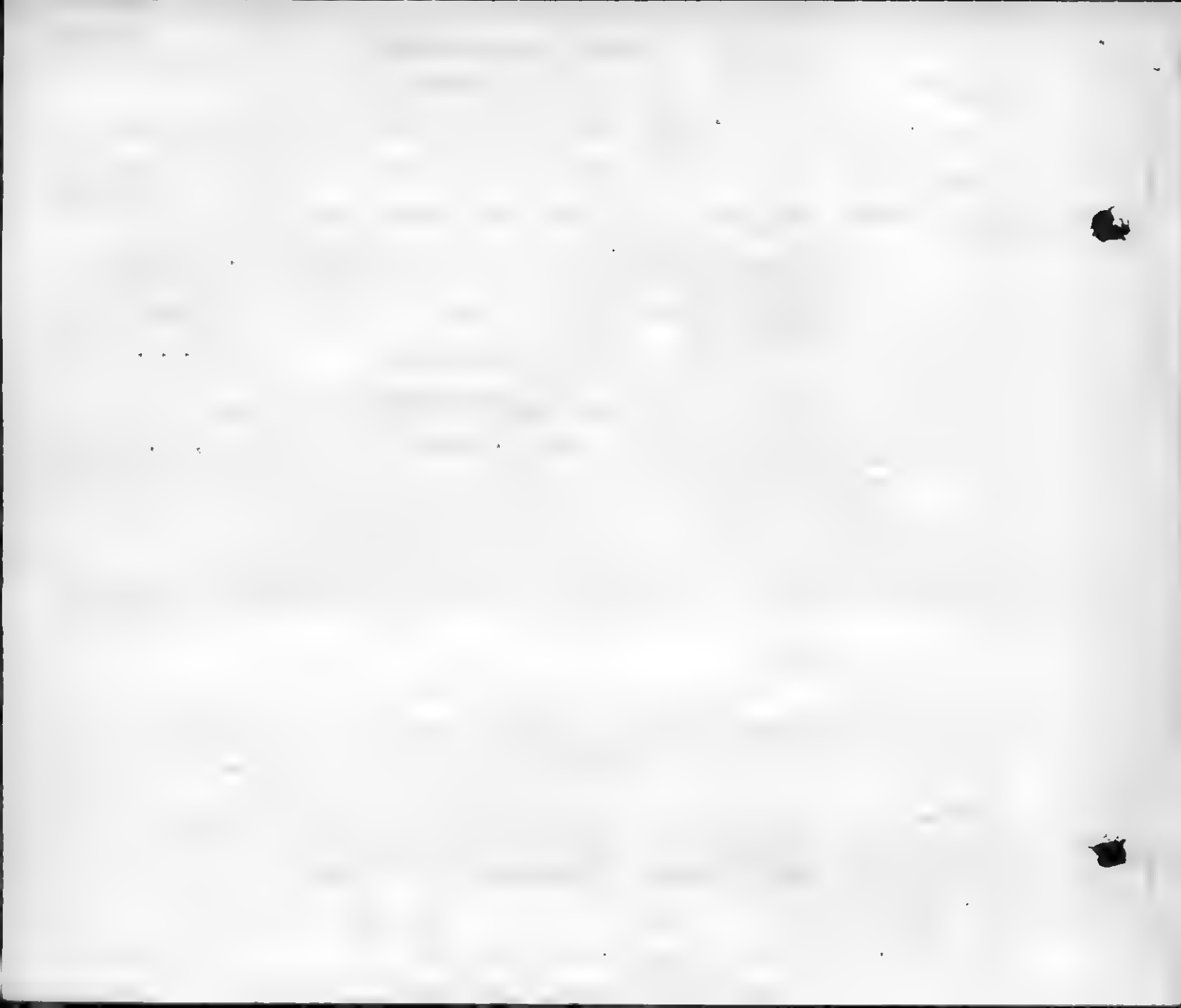
12608

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>10 hours</u>				d. STREET ADDRESS <u>5815 Wilmett Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara</u> <u>Addie</u> <u>Blum</u>				4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>12</u> <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/78</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>5</u> <u>3</u>		IF UNDER 24 HRS <u>5</u> <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edwin Scanlon</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Warnicke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ruth E. Meyers</u>		Address: <u>5815 Wilmett Road Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>4. 2 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Embolism</u> (c) <u>Peripheral Vascular Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Infarctions</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Nov. 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 11</u> , 19 <u>58</u> , and that death occurred at <u>12:22</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>F.T. PHILLIPS MD 300 Reservoir Road Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>11/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Douglas, Arizona</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>Nov 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12633

CERTIFICATE OF DEATH

12609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2990 FORSYTHE AVENUE</u>		d. STREET ADDRESS <u>2990 FORSYTHE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>KING</u> Last <u>BOISVERT</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>7</u> Year <u>1958</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 11-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARCELLUS FALLS, NY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MARTIN KING</u>		14. MOTHER'S MAIDEN NAME <u>HENORA LYCON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS MARCELLUS WATSON, SILVER SPRING, MD.</u>		Address <u>2990 FORSYTHE AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4 11-0 DUE TO <u>Anterior Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> to <u>Nov 7</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>58</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u> M.D.		ADDRESS (Street, city or town, state) <u>8641-10th Avenue Road</u> DATE SIGNED <u>11/8</u>	
PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL 11-8-58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM <u>ST MARYS CEMETARY</u>	22d. LOCATION (City, town, or county) (State) <u>NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO INC</u>		ADDRESS <u>1400 CHAPIN ST</u> 24a. REC'D BY REGISTRAR <u>DATE NOV 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12634

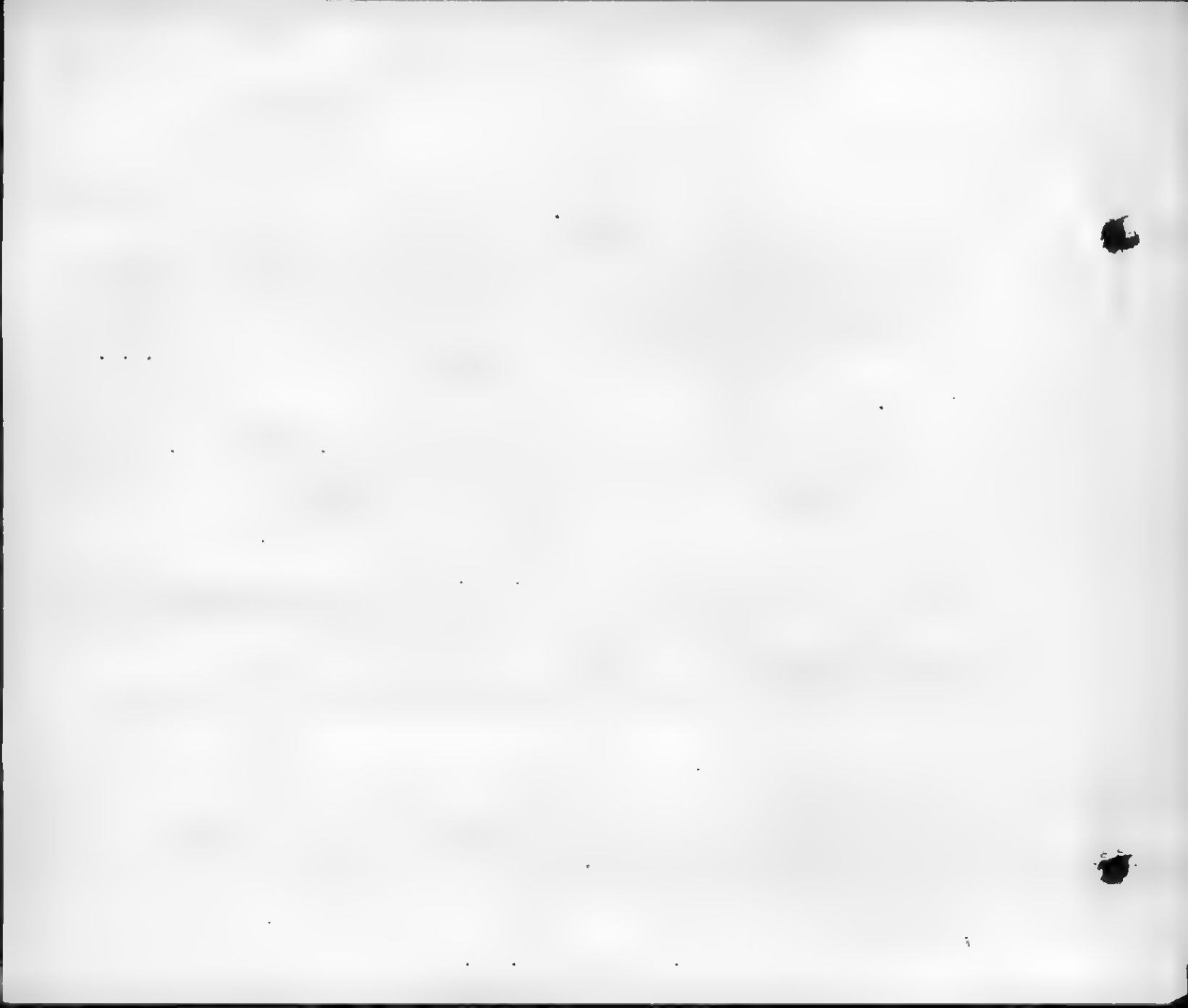
## CERTIFICATE OF DEATH

Reg. Dist. No.

12610

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>121 Martha's Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beverley</u> Middle <u>Munford</u> Last <u>Bowie</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> , Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 5, 1914</u>	
9. AGE (In years last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Journalism</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Walter R. Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Jean Laverack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic tumor to lungs, bilat</u> DUE TO (c) <u>HEMANGIOPERICYTOMA AT CERVICAL SPINE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SPINE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>November 10, 1958</u> to <u>November 15, 1958</u> , that I last saw the deceased alive on <u>November 15, 1958</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Harold R. Silberman</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/15/58</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD R. SILBERMAN, M.D.</u>				ADDRESS <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Barry Mount</u> ADDRESS <u>Cunningham Funeral Home Inc., Box 65 Alex., Va.</u>				24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



12635

CERTIFICATE OF DEATH

12611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Bethesda</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5621 Greentree Road</u>		d. STREET ADDRESS <u>5621 Greentree Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>J. Reed Bradley</u>		4. DATE OF DEATH Month Day Year <u>November 16 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1902</u>
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sup. of Claims</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pittsburg, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Herbert Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Jane Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Gertrude D. Bradley-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Seminal Vesicles</u> <u>179.7</u> DUE TO <u>metastases</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4</u> <u>1958</u> to <u>11-15</u> <u>1958</u> , that I last saw the deceased alive on <u>11-15</u> <u>1958</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew G. Prandoni</u> M.D.		ADDRESS (Street, city or town, state) <u>1150 Conn Ave NW - Wash. DC</u>	
DATE SIGNED <u>11/16/58</u>			
PHYSICIAN'S NAME (Type) <u>Andrew G. Prandoni</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>11/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12636

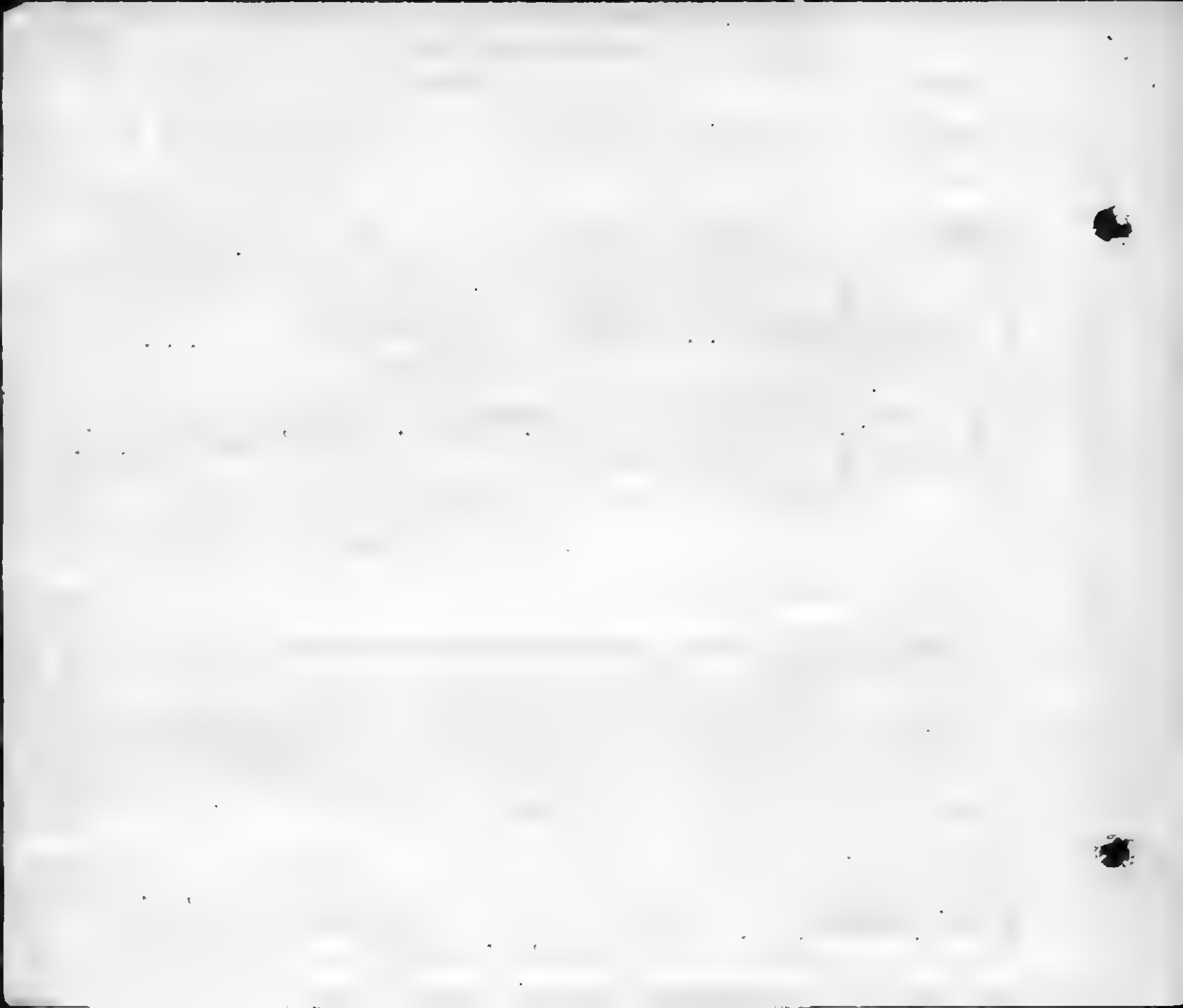
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9513 GARWOOD STREET</u>			d. STREET ADDRESS <u>9513 GARWOOD STREET</u>		
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HAROLD</u> Last <u>BRAMHALL</u>			4. DATE OF DEATH Month <u>NOV.</u> Day <u>11</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/1900</u>	9. AGE (in years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICAL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>	11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES R. BRAMHALL</u>			14. MOTHER'S MAIDEN NAME <u>EMMA ALTENBURG</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>1919-1922</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs. Mildred W. Bramhall, 9513 Garwood St. Silver Spring, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> (c) <u>Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>9/1</u> <u>1953</u> to <u>11/11</u> <u>1958</u> , that I last saw the deceased alive on <u>10/28</u> <u>1958</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1150 Corner Ave. Wash. D.C.</u> DATE SIGNED <u>11/11/58</u>					
ACTUAL SIGNATURE <u>W. Luther Hall</u>		M.D. <u>1150 Corner Ave. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>W. LUTHER HALL</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL 11/15/58</u>	22b. DATE THEREOF <u>11/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Perryville Cemetery</u>	22d. LOCATION (City town or county) (State) <u>Washington County, Pa.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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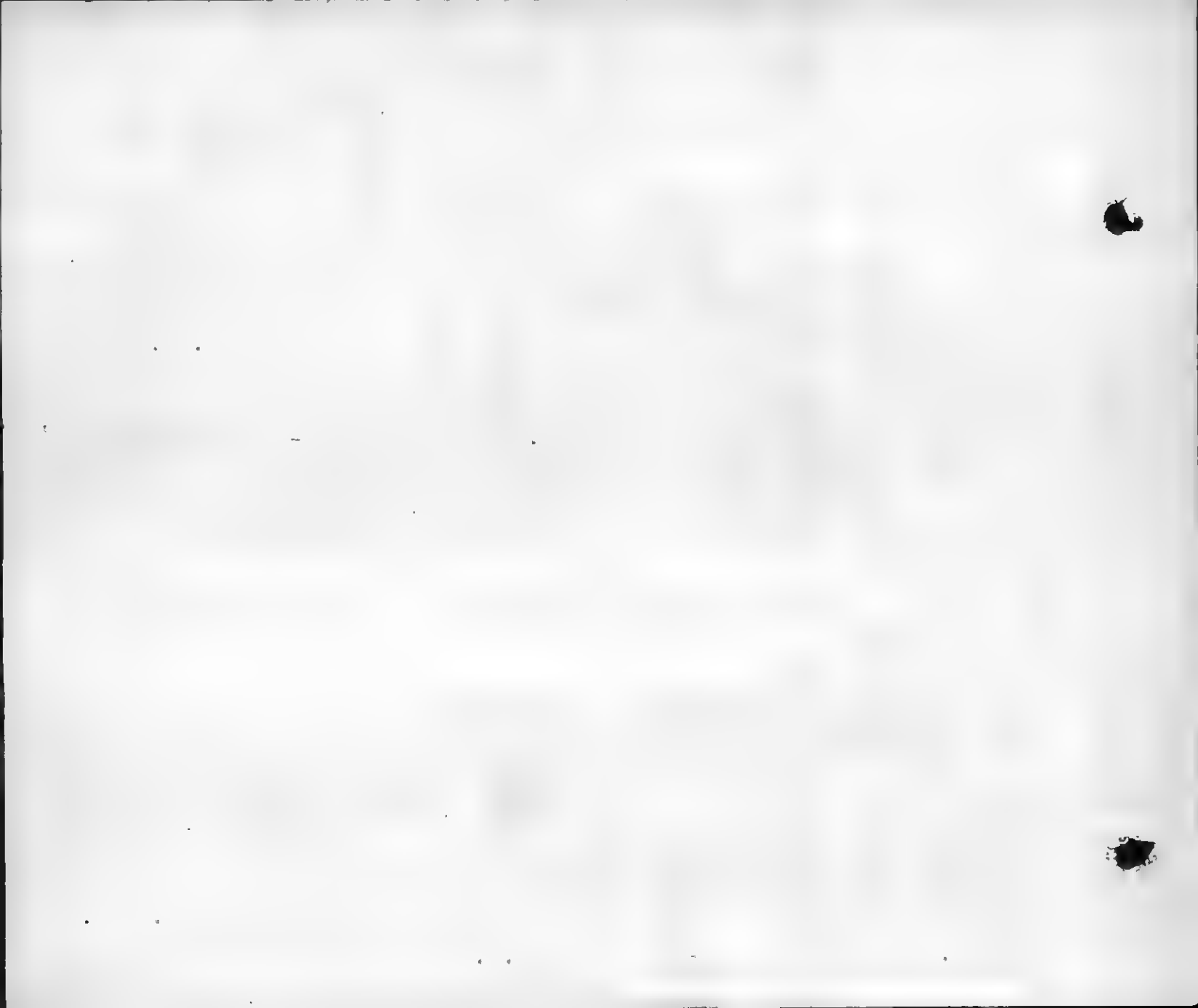
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens Nursing Home</b>		d. STREET ADDRESS <b>111 Bishop Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Young</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/17/1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Mike Young</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Small</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Donald Crawford-111 Bishop Lane</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of coronary arteries</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Coronary atherosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertension, diabetes mellitus, chronic bronchitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>9</b> p. m. Month <b>11</b> Day <b>17</b> Year <b>1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/17/58</b> to <b>11/17/58</b> , that I last saw the deceased alive on <b>11/17/58</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Young</b> M.D. <b>11/17/58</b>			
PHYSICIAN'S NAME (Type) <b>William Young</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company-Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 17 '58</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10104 Lordin Ave</b>				d. STREET ADDRESS <b>10104 Lordin Ave.</b>			
3 NAME OF DECEASED (Type or print) <b>Nettie Isabel Hill Brougham</b>				4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>1958</b>			
5 SEX <b>F</b>	6. COLOR OR RACE <b>CAUC.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>27 October 1876</b>	9 AGE (In years last birthday) <b>82 yrs</b>	IF UNDER 1 YEAR Months <b>20</b> Days <b>20</b> Hours <b>20</b> Min <b>20</b>		IF UNDER 74 HRS Months <b>20</b> Days <b>20</b> Hours <b>20</b> Min <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GENEALOGIST</b>		11 BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
13 FATHER'S NAME <b>Sullivan D. Hill</b>				14 MOTHER'S MAIDEN NAME <b>Caroline M. Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>574-16-6773</b>		17 INFORMANT <b>Allen Ross Brougham</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>444X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4-5 yrs</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1940</b> to <b>16 Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>14 Nov</b> , 19 <b>58</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above				ADDRESS (Street, city or town, state) <b>9606 Colisville Rd</b>			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.				DATE SIGNED <b>11/16/58</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>				ADDRESS <b>Silver Spring Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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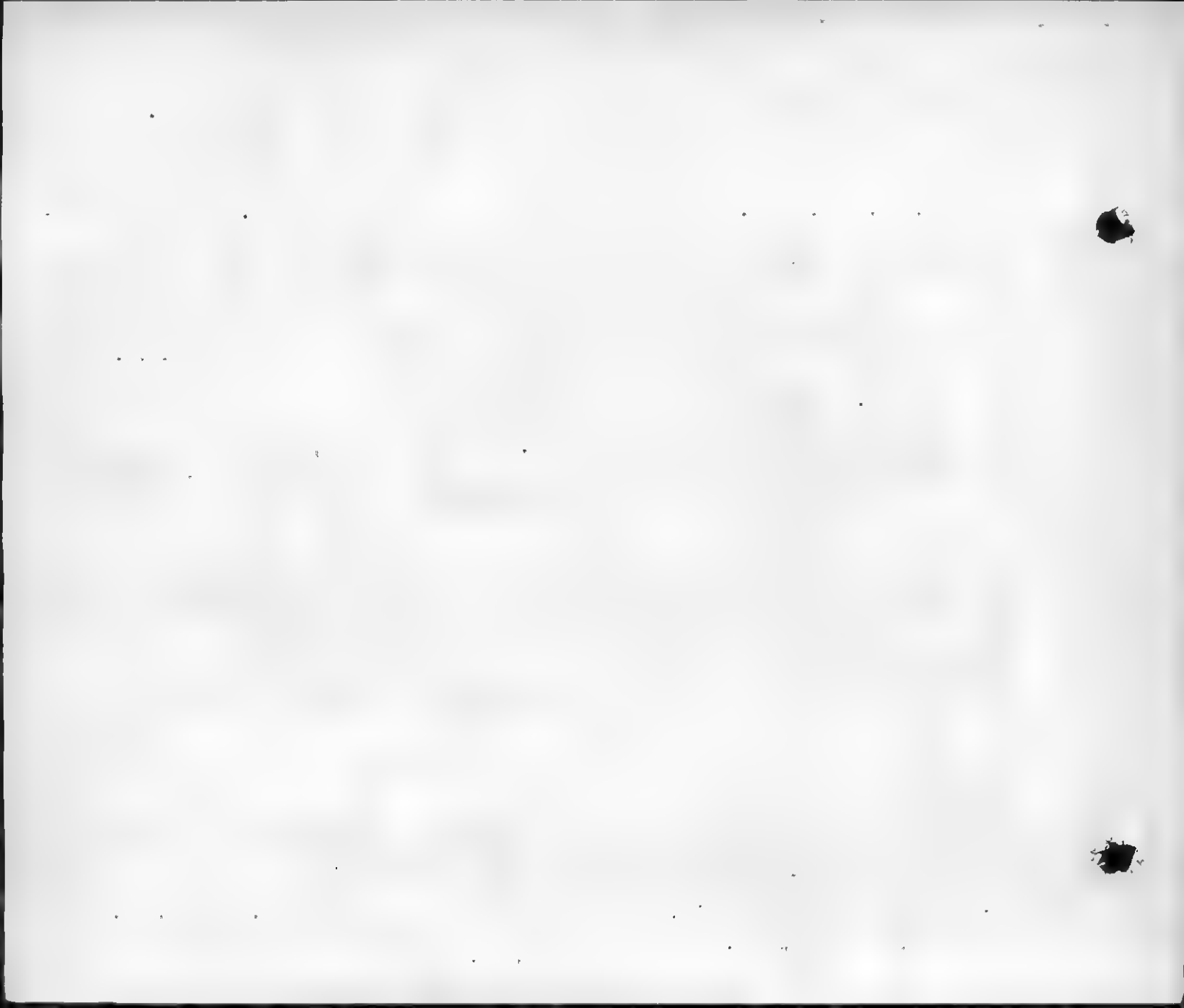
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>	c. LENGTH OF STAY IN 1b <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montg. Co. Gen. Hosp.</b>		d. STREET ADDRESS <b>4513 Muncaster Mill Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>LOLA</b> Middle <b>PARKER</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/73</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>58</b> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STILES O. PARKER</b>		14. MOTHER'S MAIDEN NAME <b>ALICE TILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Elizabeth Lawson</b>		Address <b>6247 Lee Highway Arlington, Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>11/8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pomehrey, Inc.</b> <b>Raymond E. Pomehrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Carl S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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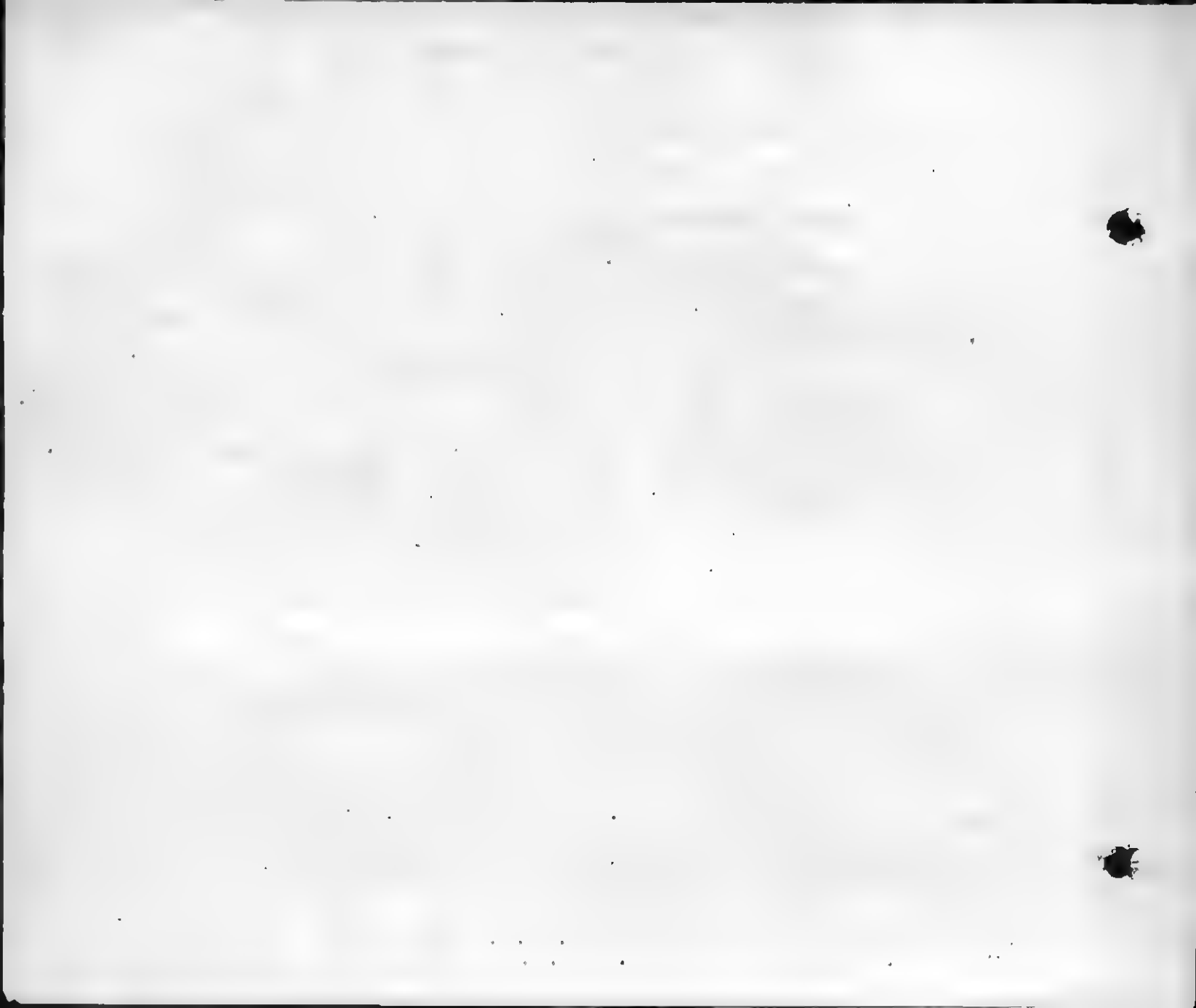
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY in 1b <b>6 months</b>		d. STREET ADDRESS <b>8013 TAKOLA AVENUE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8013 TAKOLA AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>A.</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/92</b>
9. AGE (In years last birthday) <b>66 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN OTT</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE SCHULER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MRS. S. M. DEFFINBAUGH</b>		Address <b>SILVER SPRING</b> <b>8904 CLOVER AVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Degeneration</b> DUE TO (c) <b>Generalized Arterio Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 19, 1958</b> , to <b>Nov 18, 1958</b> , that I last saw the deceased alive on <b>Nov 14, 1958</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Merrill M. Cross M.D.</b>		ADDRESS (Street, city or town, state) <b>8248 G-14 AVE. BALTIMORE, MARYLAND.</b>	
DATE SIGNED <b>11/18/58</b>			
PHYSICIAN'S NAME (Type) <b>MERRILL M. CROSS M.D. SILVER SPRING, Maryland</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/20/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. J. COLLINS</b>		ADDRESS <b>WASH. D.C. 3821 41th. ST. N.W.</b>	
24a. REC'D BY REGISTRAR <b>NOV 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Funn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



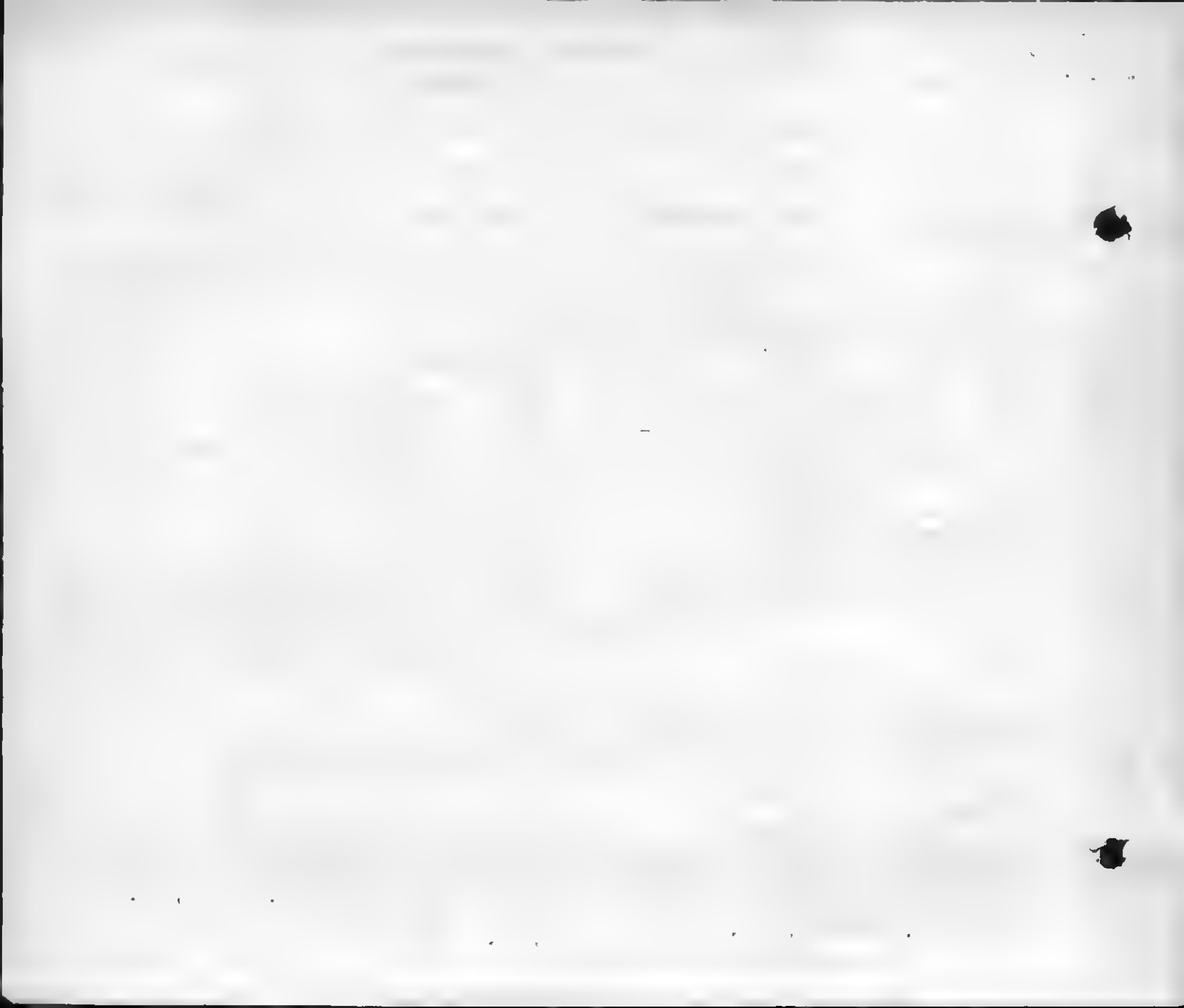
12641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban - 3800 Old Georgetown Rd.</u>				d. STREET ADDRESS <u>4407 Birchfield Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Belle</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22 - 1909</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spec. Projects (clerical)</u>				11. BIRTHPLACE (State or foreign country) <u>NAVY Dept. U.S. Washington DC</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William CARROLL BELL</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Forest GIBSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-28-1808</u>		17. INFORMANT <u>Daughter</u> <u>Joan Anthony - 10411 Euclid Ave. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MIDBRAIN compression</u> DUE TO <u>Cerebral edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal carotid thrombosis</u> (c) <u>11 days</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Nov</u> Day <u>14</u> Year <u>1958</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 9</u> , 19 <u>58</u> , to <u>Nov 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>58</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Lord</u>				ADDRESS (Street, city or town, state) <u>2025 Eye St NW WASH DC</u>			
DATE SIGNED <u>11/14/58</u>							
PHYSICIAN'S NAME (Type) <u>John T. Lord MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETRY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S NAME <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.





FOR STATE  
HEALTH DEPT.

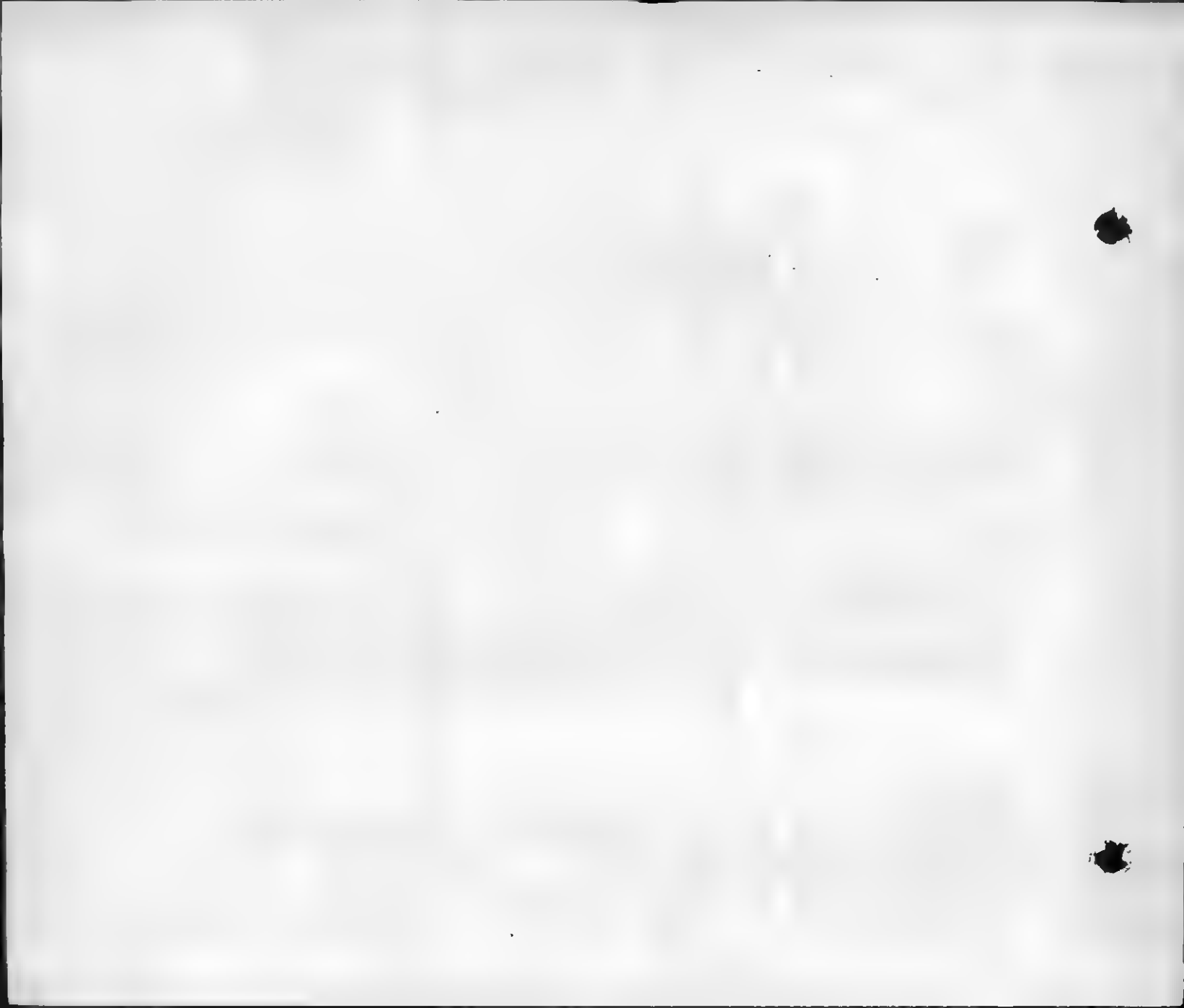
12642

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4814 Bradley Blvd Apt 21</u>		d. STREET ADDRESS <u>4814 Bradley Blvd Apt 21</u>	
3. NAME OF DECEASED (Type or print) <u>John Criststad Bryn</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-02</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V. Adm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Helmer Bryn</u>		14. MOTHER'S MAIDEN NAME <u>Laura Criststad</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Eliz Bryn (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of stomach contents</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Apparently became ill and fell.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Found dead in bath room of his home with head submerged in bath tub half filled with water. Neg. drowning for</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) <u>SILVER SPRING MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawlin's Son</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Clara E. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12643

## CERTIFICATE OF DEATH

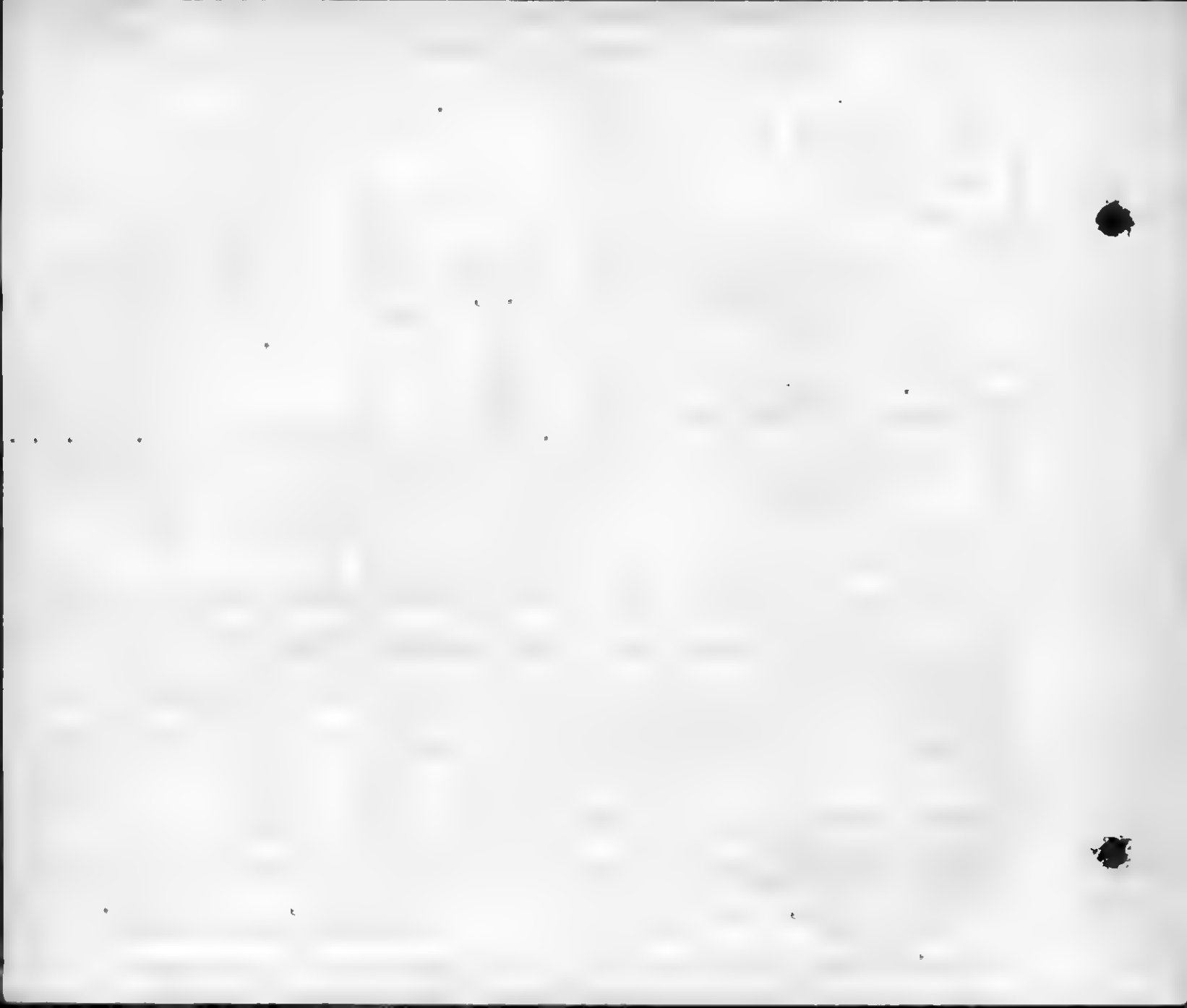
12619

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Mont.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Sanitarium</b>		d. STREET ADDRESS <b>3710 Underwood Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JULIA P. BURGESS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1872</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Wm. P. Zollinger</b>		14. MOTHER'S MAIDEN NAME <b>Florence Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Newbold Burgess 1650 Harvard Apts. Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIO SCLEROSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 14, 1955</b> , to <b>Nov. 6, 1958</b> , that I last saw the deceased alive on <b>Nov. 6, 1958</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry M. Howden</b> M.D.		DATE SIGNED <b>Nov. 6, 1958</b>	
PHYSICIAN'S NAME (Type) <b>HENRY M. HOWDEN</b>		<b>Chevy Chase, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Rutaw Place</b>		24a. REC'D BY REGISTRAR <b>Nov 10 1958</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

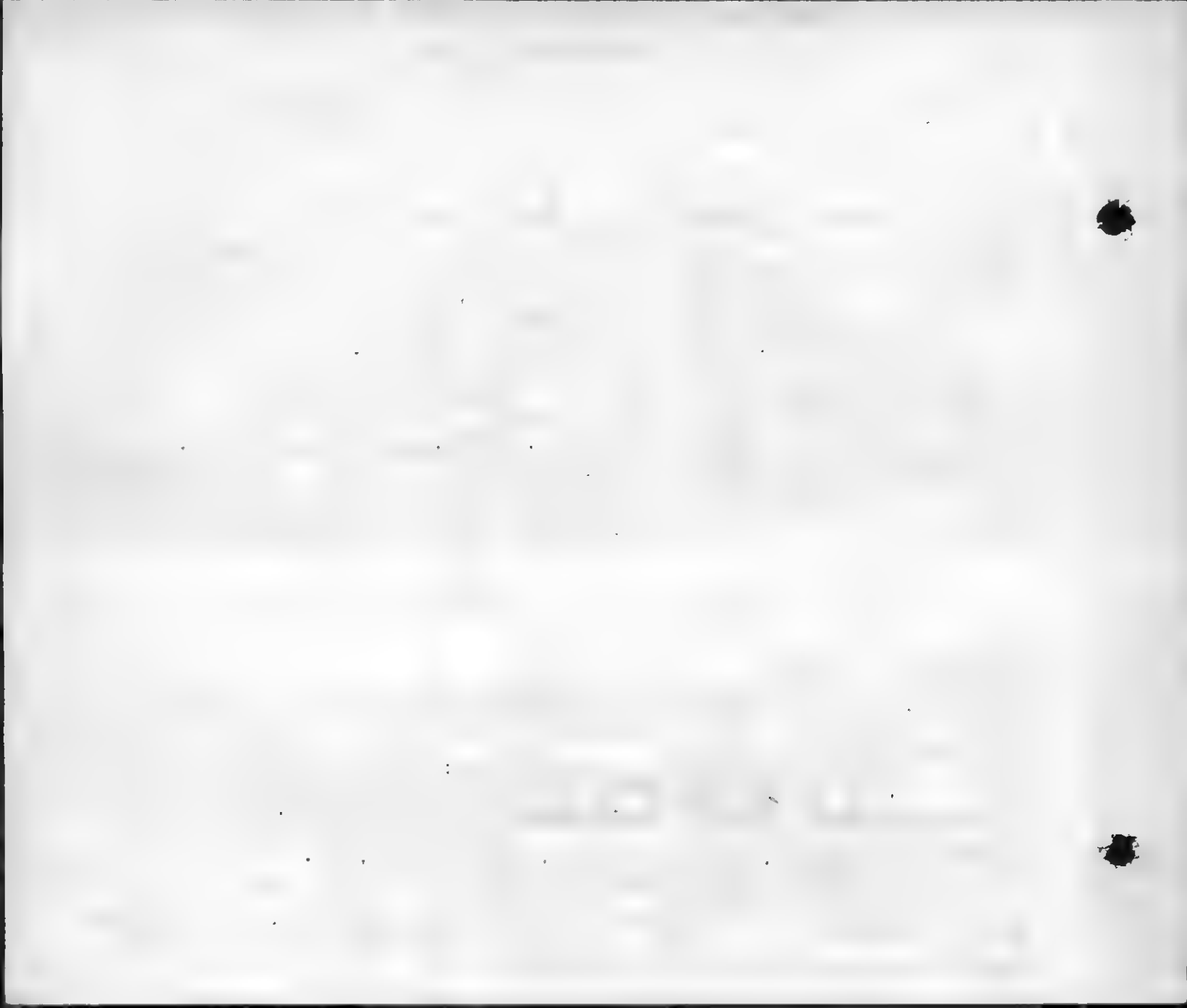
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12644 CERTIFICATE OF DEATH

12620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Rhode Island</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Providence</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Lebeau Gardens Nursing Home</b>			d. STREET ADDRESS <b>156 Medway Street</b>		
3. NAME OF DECEASED (Type or print) <b>Herbert Stevenson Busey</b>			4. DATE OF DEATH <b>November 20</b> Day Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 21, 1879</b>		9. AGE (In years and birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Designer (ret.)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Machine</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>William McClanahan Busey</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Emelia Brown</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>035 07 3927</b>			17. INFORMANT Address <b>Mrs. Mary B. Fay, Takoma Park, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyperpyrexia</b> <b>715X</b> DUE TO <b>Septicemia, Probably Staphylococcal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Decubitus ulcers, Buttocks, Old</b> (c)					INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Oct 4</b> , 19 <b>57</b> , to <b>Nov 20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 20</b> , 19 <b>58</b> , and that death occurred at <b>4:45 p</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.			ADDRESS (Street, city or town, state) <b>10609 Concord St.</b>		
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>			DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>Nov 22, 1958</b>		<b>Mount Olivet Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
<b>J. Arthur Walters</b>		<b>254 Carroll St NW</b>		<b>NOV 24 '58</b>	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE			
<b>Arthur S. Smith</b>		<b>Arthur S. Smith</b>			



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12645

## CERTIFICATE OF DEATH

12621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Rhode Island</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens Nursing Home</b>				e. STREET ADDRESS <b>156 Medway Street</b>			
3. NAME OF DECEASED (Type or print) <b>Julia Bridener Busey</b>				4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 26, 1877</b>	
9. AGE (In years last birthday) yrs <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Maurice Bridener</b>				14. MOTHER'S MAIDEN NAME <b>Julia A. Curley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mary B. Fay, Address: Johns Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>30 Min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Cerebral Thrombosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov 1</b> , 19 <b>58</b> to <b>Nov 15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 13</b> , 19 <b>58</b> , and that death occurred at <b>5:30 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.				ADDRESS (Street, city or town, state) <b>10609 Concord St. Kensington, Maryland</b>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Nov 18, 1958</b>		<b>Mt. Olivet Cemetery</b>		<b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith H. Harker</b>				ADDRESS <b>254 Carroll St. N.E.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>John S. Hanks</b>			





12599

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u>	
c. LENGTH OF STAY IN 1b <u>6hr 47min</u>		d. STREET ADDRESS <u>434 W. 20th ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Mackenzie</u> Last <u>Byrne</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-9-22</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>America</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Daniel J. Byrne</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mackenzie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accidents</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia Senilis</u> DUE TO (c) <u>Circulatory Shock</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-6-58</u> , 19 <u>58</u> , to <u>11-7-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-6-58</u> , 19 <u>58</u> , and that death occurred at <u>1:22 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED.	
ACTUAL SIGNATURE <u>Ramsey C. Claggett</u> M.D.		<u>1600 Carroll Ave. Washington, D.C.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REBURY (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov. 8, 1958</u>	<u>Rock Creek Cemetery</u>	<u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Galters</u> ADDRESS <u>254 Carroll St NW DC</u>		24. REC'D BY REGISTRAR <u>11-13-58</u> 25. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



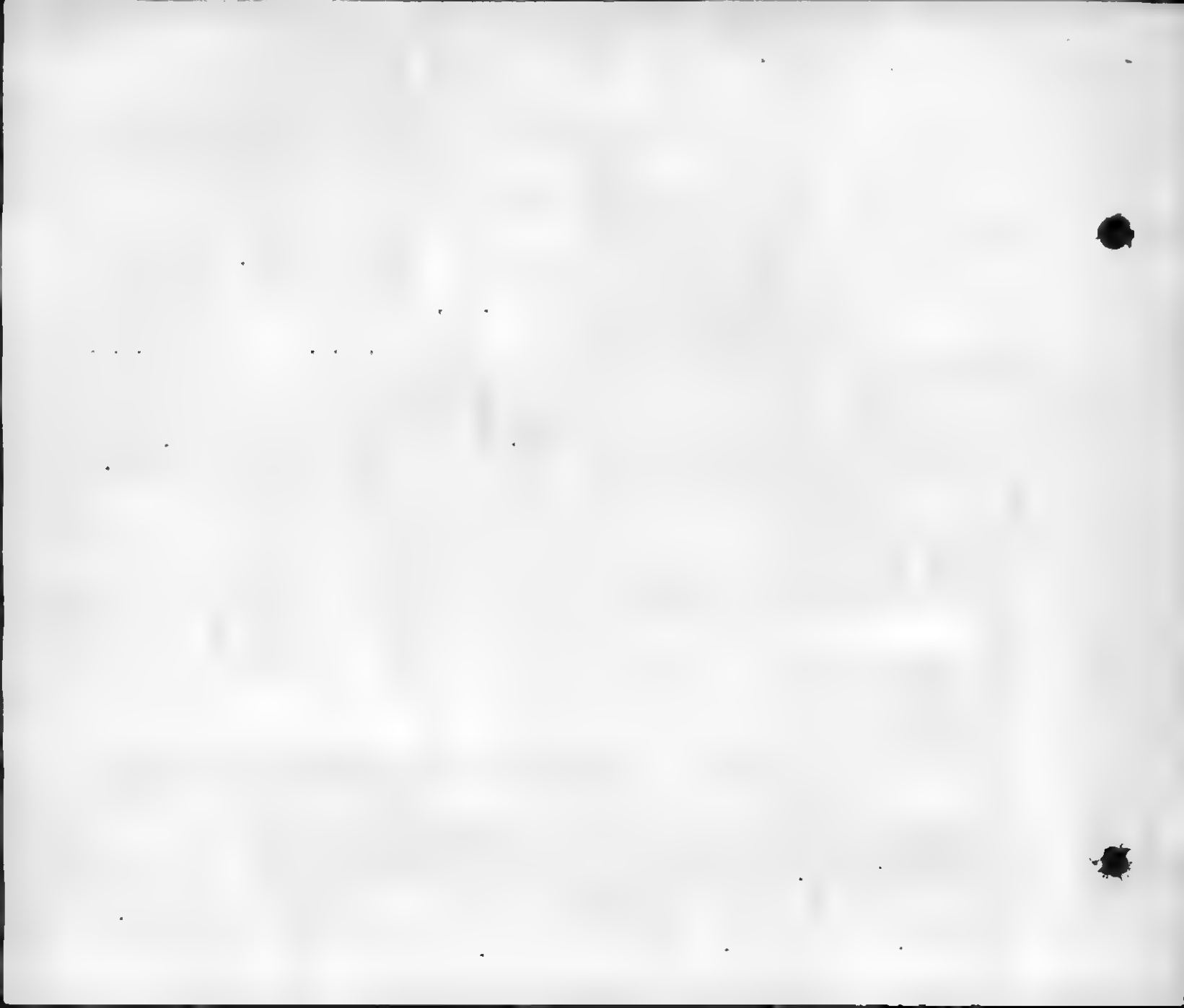
12646

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>905 GIST AVENUE</b>		e. STREET ADDRESS <b>905 GIST AVENUE</b>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH DILLON CALLAHAN</b>		4. DATE DEATH <b>NOV. 24 19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 31, 1879</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Dillon</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Gallagher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Joseph LeClair, 905 Gist Ave. Silver Spring, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SUDDEN</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <b>11/24/58</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/26/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WANNER E. PUMPHREY, INC.</b> <i>Raymond G. Giska</i>		24a. REC'D BY REGISTRAR DATE <b>NOV 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



12647

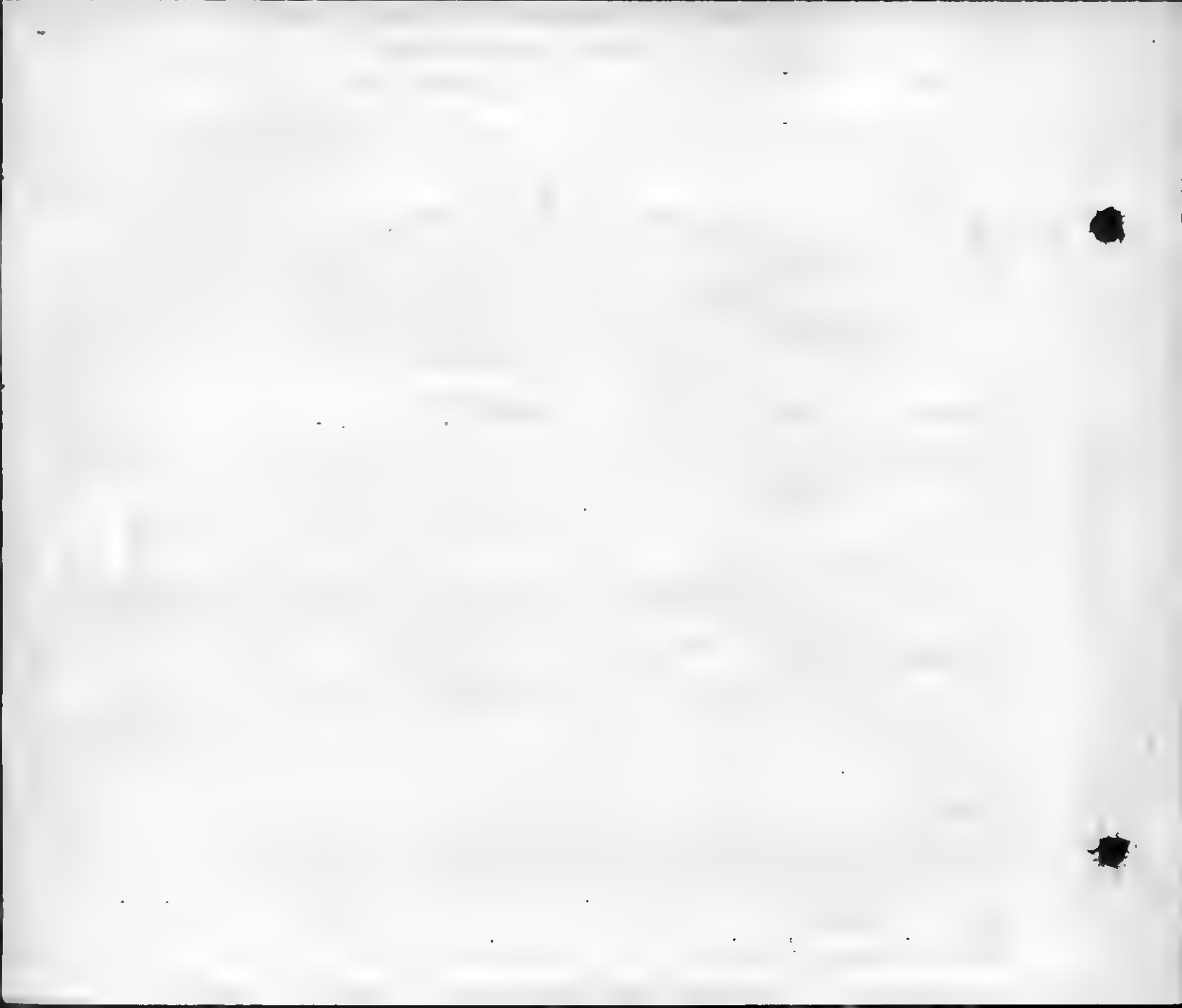
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN 1b <u>30 MINUTES</u>				d. STREET ADDRESS <u>2819 IVYDALE STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSP. BETHESDA, MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Philip</u> First <u>ANTHONY</u> Middle <u>CAMARANO</u> Last				4. DATE OF DEATH <u>NOVEMBER 27</u> 19 <u>58</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 12, 1953</u> yrs. 5	
9. AGE (In years last birthday) <u>5</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>LANSING, MICHIGAN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>ANTHONY MICHAEL CAMARANO</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA CATHERINE RINEHART</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. Anthony M. Camarano</u> Address <u>3819 IVYDALE ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>474X CARDIAC ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>ACUTE TRACHEO LARYNGITIS, SEVERE</u> DUE TO (c) <u>E LARYNGEAL EDEMA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 26, 1958</u> , to <u>November 27, 1958</u> , that I last saw the deceased alive on <u>November 27, 1958</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. <u>11502 GRANDVIEW AVE.</u> ADDRESS (Street, city or town, state) <u>SILVER SPRING, MD.</u> DATE SIGNED <u>Nov. 27, 1958</u>				PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City town or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12648

## CERTIFICATE OF DEATH

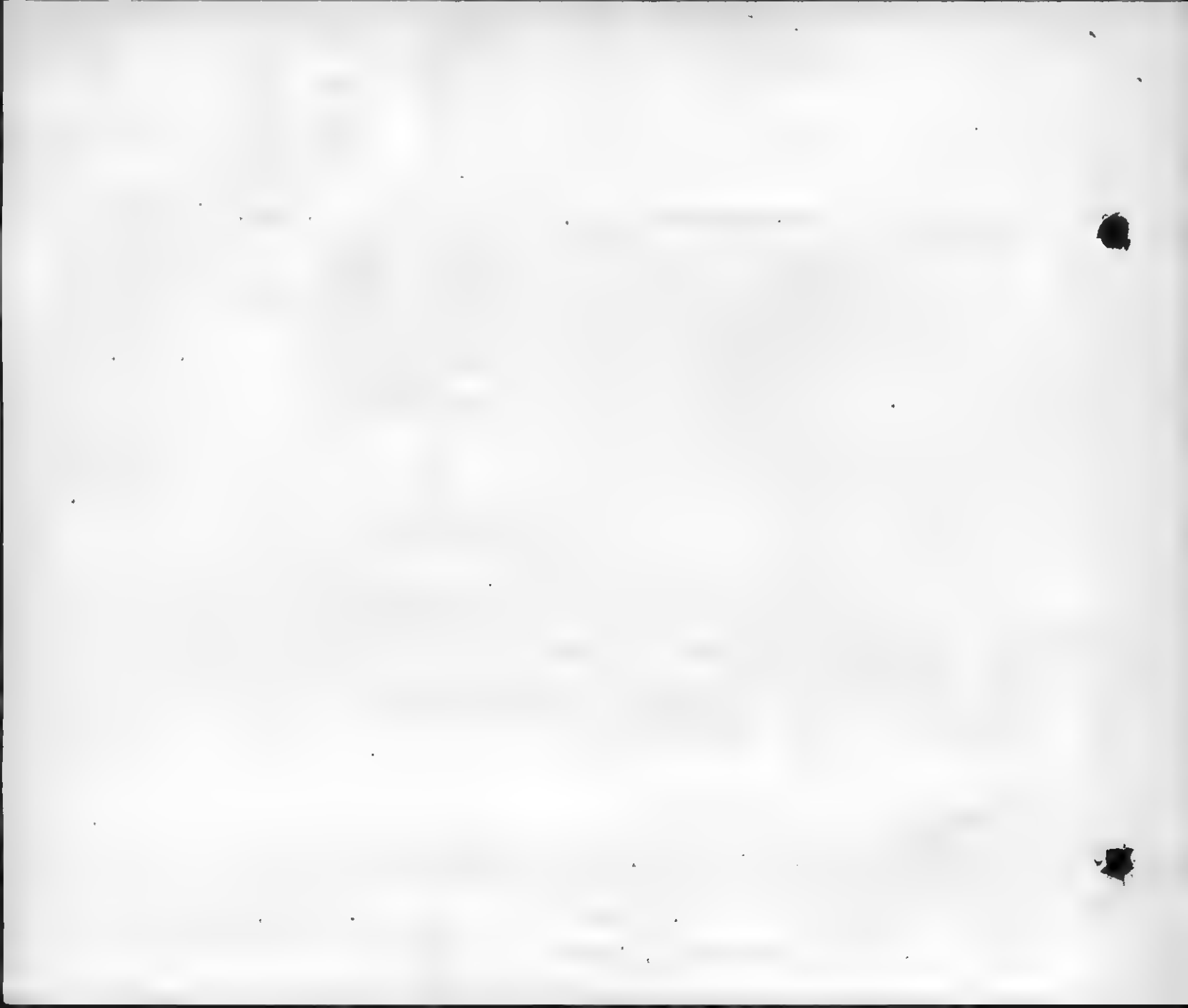
12625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>21 days</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>A Wheaton</u> d. STREET ADDRESS <u>2318 Blueridge Ave., Apt. 105</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alyce Brooks Campbell</u>		4. DATE OF DEATH Month Day Year <u>November 26, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 19, 1916</u>
9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months Days Hours M n	IF UNDER 24 HRS Months Days Hours M n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter A. Hall</u>		14. MOTHER'S MAIDEN NAME <u>Mirtle Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>461-09-7199</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Bilateral Ureteral Obstruction</u> DUE TO (c) <u>Carcinoma of Cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>November 5, 1958</u> to <u>November 26, 1958</u> , that I last saw the deceased alive on <u>November 26, 1958</u> , and that death occurred at <u>6:16 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Dillon</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
DATE SIGNED <u>11-27-58</u>			
PHYSICIAN'S NAME (Type) <u>John S. Dillon, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>
22d. LOCATION (City town or county) <u>Ft. Worth, Texas</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 1 58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Pumphrey</u>	

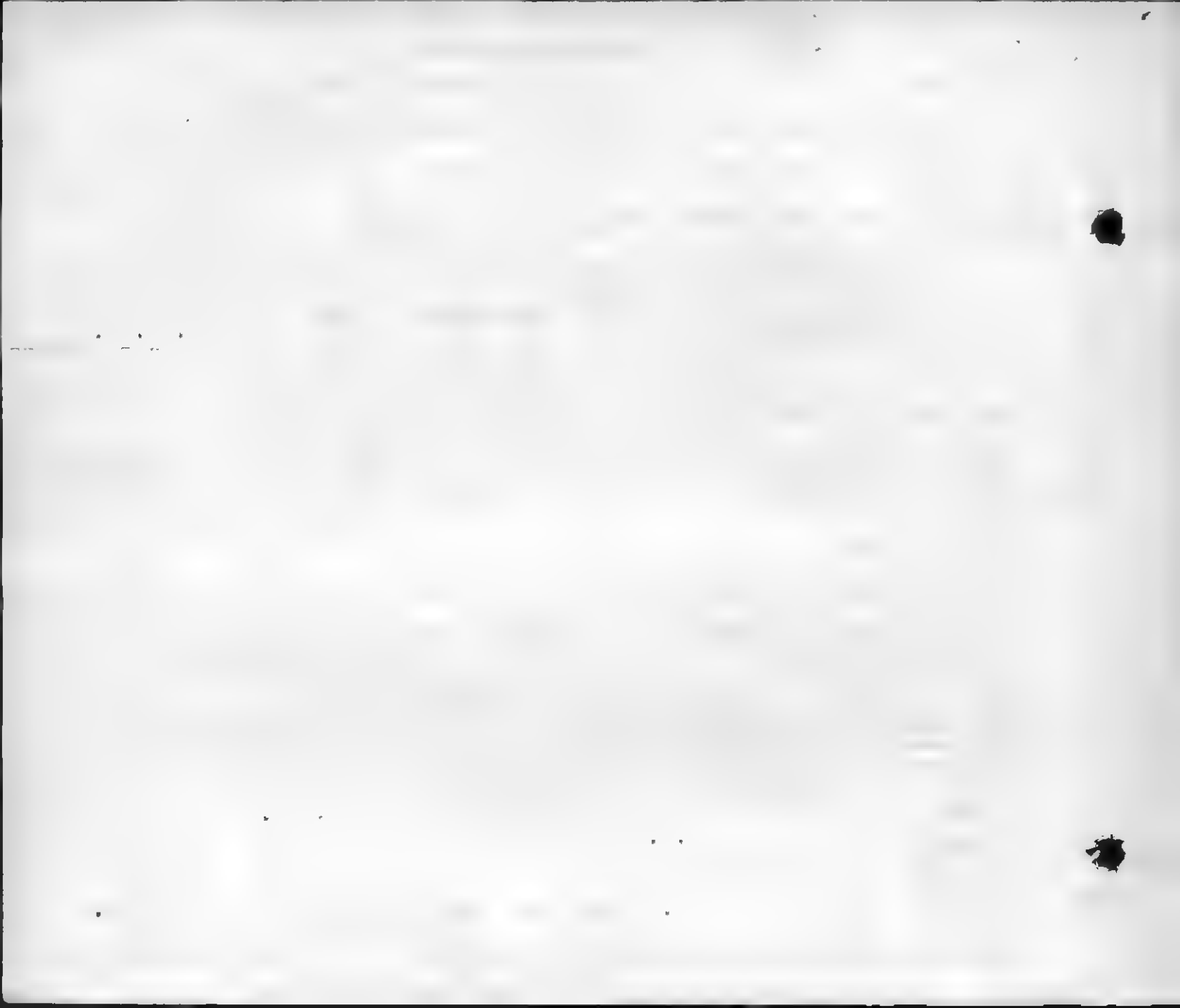
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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154 9/54



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12649

## CERTIFICATE OF DEATH

12627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>807 STERLING ROAD</b>				d. STREET ADDRESS <b>807 STERLING ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>AMELIA</b> Last <b>CARMAN</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/23/68</b>	
9. AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ROBERT B. MINAR</b>				14. MOTHER'S MAIDEN NAME <b>HELEN A. ANDREWS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT Address <b>Mrs. Louis F. Miller, 807 Sterling Rd. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of rectum</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arterio-sclerotic heart disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>10/15</b> 19 <b>58</b> to <b>11/18</b> 19 <b>58</b> that I last saw the deceased alive on <b>Nov 17</b> 19 <b>58</b> , and that death occurred at <b>7:30 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4201 New Hamp ave NW Washington</b> DATE SIGNED <b>Chas W Harnsberger</b>							
ACTUAL SIGNATURE <b>Chas W Harnsberger</b> M.D.							
PHYSICIAN'S NAME (Type) <b>CHAS. W. HARNSEBERGER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SARANAC CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SARANAC, MICHIGAN</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond G. Zicka</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



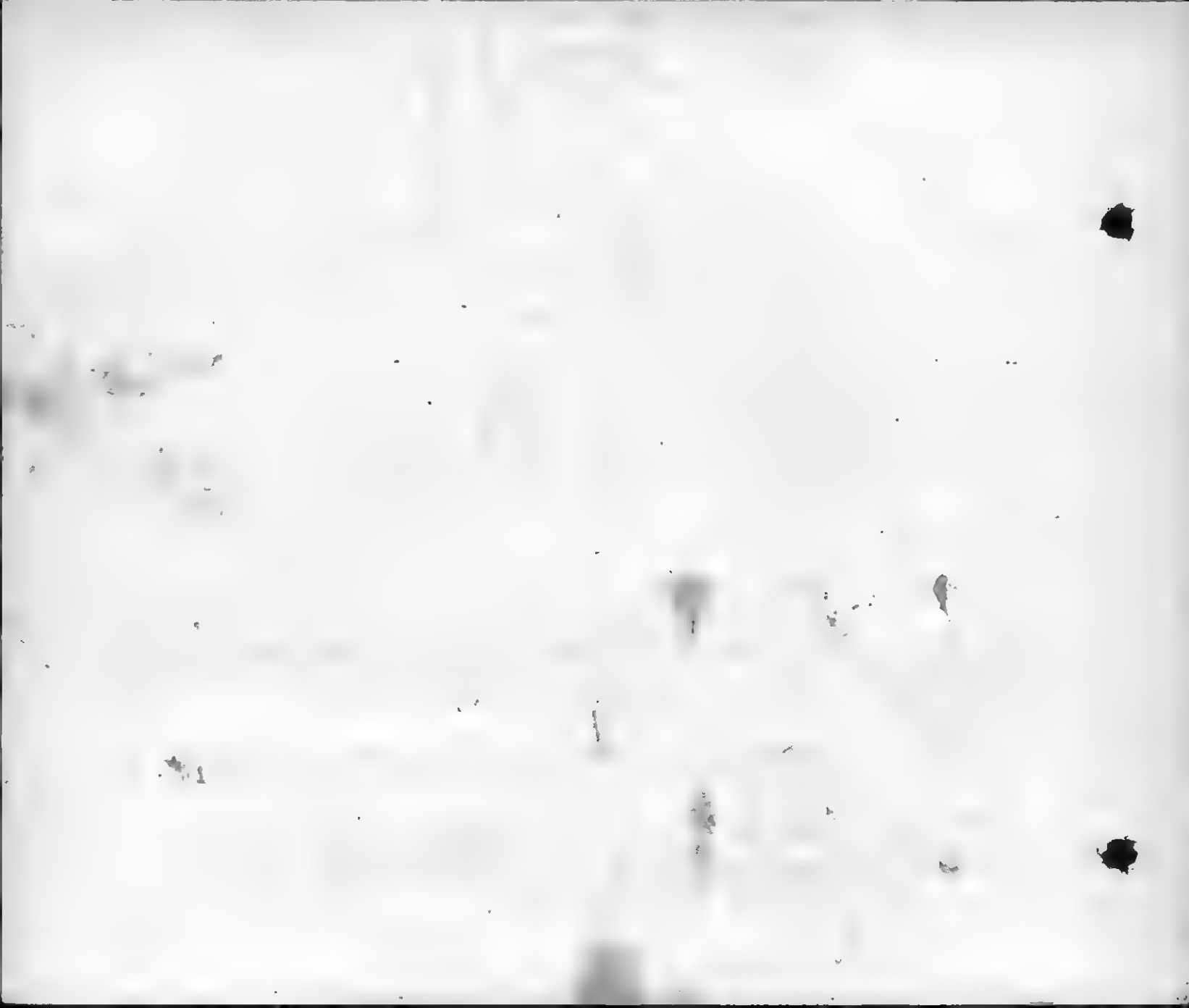
12650

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>52 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>439 Williams Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Frank Carnell</b>		4. DATE OF DEATH Month Day Year <b>November 8 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 1, 1894</b> 9. AGE (In years last birthday) yrs <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Carnell</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>yes WW I</b>		16. SOCIAL SECURITY NO. <b>705 07 9705</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 17, 1958</b> , to <b>November 8, 1958</b> , that I last saw the deceased alive on <b>November 8, 1958</b> , and that death occurred at <b>12:40 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James M. Marsh, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
DATE SIGNED <b>11-8-58</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 11, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 10 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12651

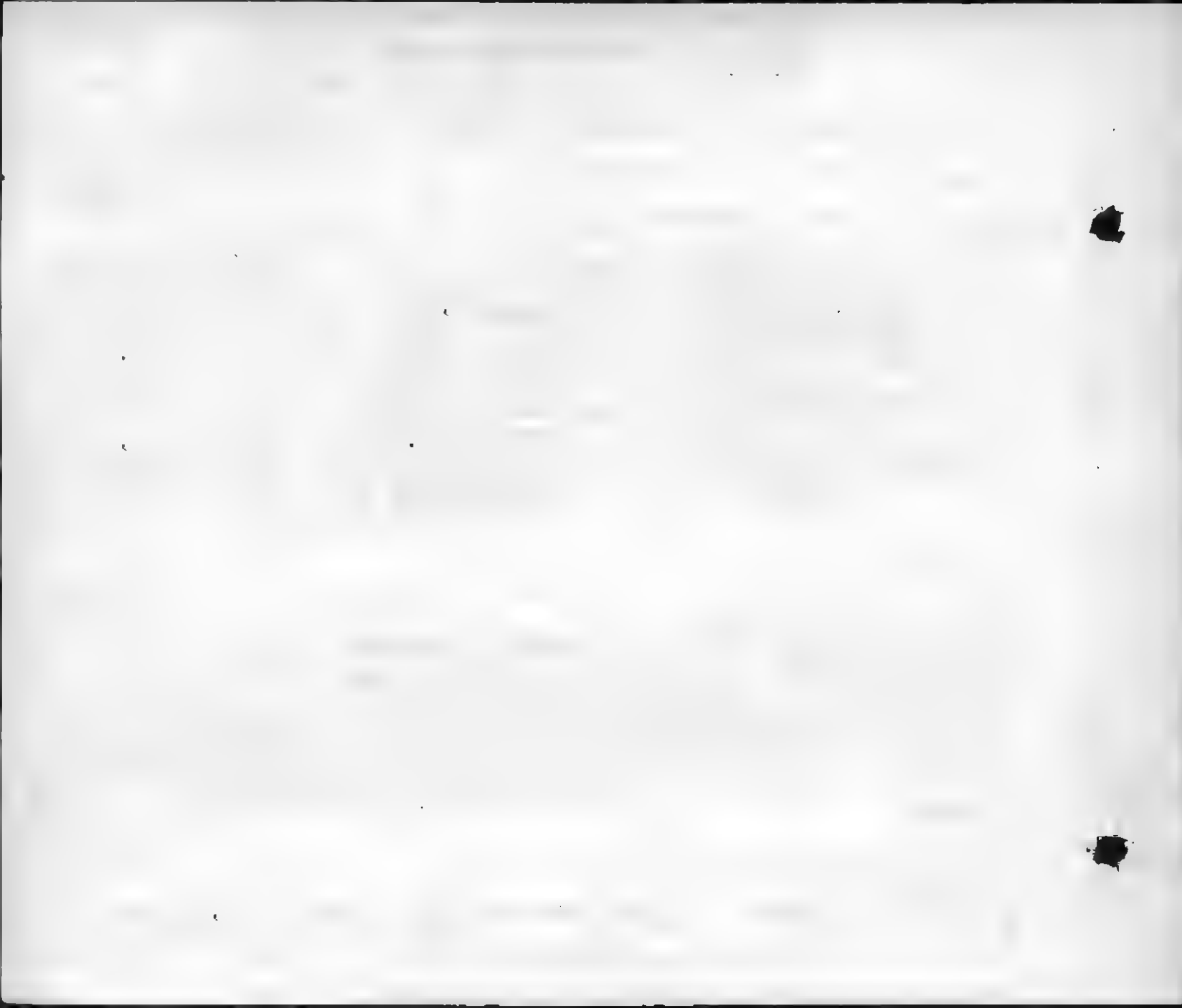
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>GAITHERSBURG, MD</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE</b> <b>CEPHAS</b>				4. DATE OF DEATH Month Day Year <b>11/ 4/ 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1875</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>SAMUEL FISHER</b>				14. MOTHER'S MAIDEN NAME <b>HARRIETT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Hester M. Dorsey</b>		Address <b>Gaithersburg, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interoskeletal cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10, 1952</b> to <b>Nov 11, 1958</b> , that I last saw the deceased alive on <b>Nov 1, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>11/6/58</b> ACTUAL SIGNATURE <b>James P. Keras</b> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert S. Howard</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





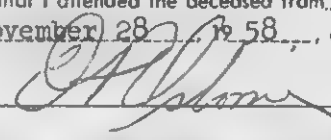


# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12652

## CERTIFICATE OF DEATH

12630

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>21 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Taiwan</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laoshiun</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>Navy Base</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Shao</b> Middle <b>Hua</b> Last <b>CHANG</b>			4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1958</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Mongolian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-22-15</b>	
9. AGE (In years last birthday) <b>43</b> yrs		IF UNDER 1 YEAR Months <b>43</b>		IF UNDER 24 HRS Days <b>43</b>		Hours <b>43</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Armed Forces</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chinese Marine Corps</b>		11. BIRTHPLACE (State or foreign country) <b>China</b>		12. CITIZEN OF WHAT COUNTRY <b>China</b>	
13. FATHER'S NAME <b>Shaohua Yutien CHANG</b>				14. MOTHER'S MAIDEN NAME <b>Wenchen WANG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>- -</b>		17. INFORMANT <b>Official Navy Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatocarcinoma with metastasis</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>November 8, 1958</b> to <b>November 29, 1958</b> , that I last saw the deceased alive on <b>November 28, 1958</b> , and that death occurred at <b>4:35 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE 		M. D. <b>U. S. Naval Hospital, NNM</b>		ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b>		DATE SIGNED <b>12-1-58</b>	
PHYSICIAN'S NAME (Type) <b>D. P. OSBORNE, CAPT, MC, USN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>12-5-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town or county) _____ (State) _____ <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>Adams Funeral Home, 4748 Wisc, Ave., NW, Wash, DC</b>		ADDRESS <b>4748 Wisc, Ave., NW, Wash, DC</b>		24a. REC'D BY REGISTRAR <b>DEC 4 58</b>		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12601 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>6 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7511 Carroll Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rene Guide Chatel</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 25, 1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ad.</u>		11. BIRTHPLACE (State or foreign country) <u>Yonkers, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>LEWIS P. CHATEL</u>			
14. MOTHER'S MAIDEN NAME <u>Clemente</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.I.</u>			
16. SOCIAL SECURITY NO. <u>579-12-3668</u>				17. INFORMANT <u>Mrs Lucille M. Chatel, 1100 F. N. E. Wash DC</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-27-58</u>			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF <u>DECEMBER 1, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON ARLCO. VA</u>	
23. SIGNATURE OF DIRECTOR <u>Arthur S. Brand</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Brand</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transfer permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

12653

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 12-11-58 at

CERTIFICATE OF DEATH

12632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>27</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>32 Eastmore Drive</b>		d. STREET ADDRESS <b>132 Eastmore Dr</b>	
3. NAME OF DECEASED (Type or print) <b>M. GRACE CIANGU</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>30</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Domenic De Lorenzo</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Ricciardi</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Peter J. Ciango</b>	
17. INFORMANT <b>Peter J. Ciango</b>		Address <b>3134 24th St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Carcinoma of liver</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 24, 1958</b> , to <b>Nov 30, 1958</b> that I last saw the deceased alive on <b>Nov 30, 1958</b> , and that death occurred at <b>12:24</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Eugene J. [Signature]</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>1746 R St. Dec 1, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Eugene J. [Signature]</b>			
22a. BURIAL (CREMATION, REMOVAL) (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-3-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Real Funeral Home</b>		ADDRESS <b>4812 In Ave West, 102</b>	
24a. REC'D BY REGISTRAR <b>DEC 4 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	



12654

## CERTIFICATE OF DEATH

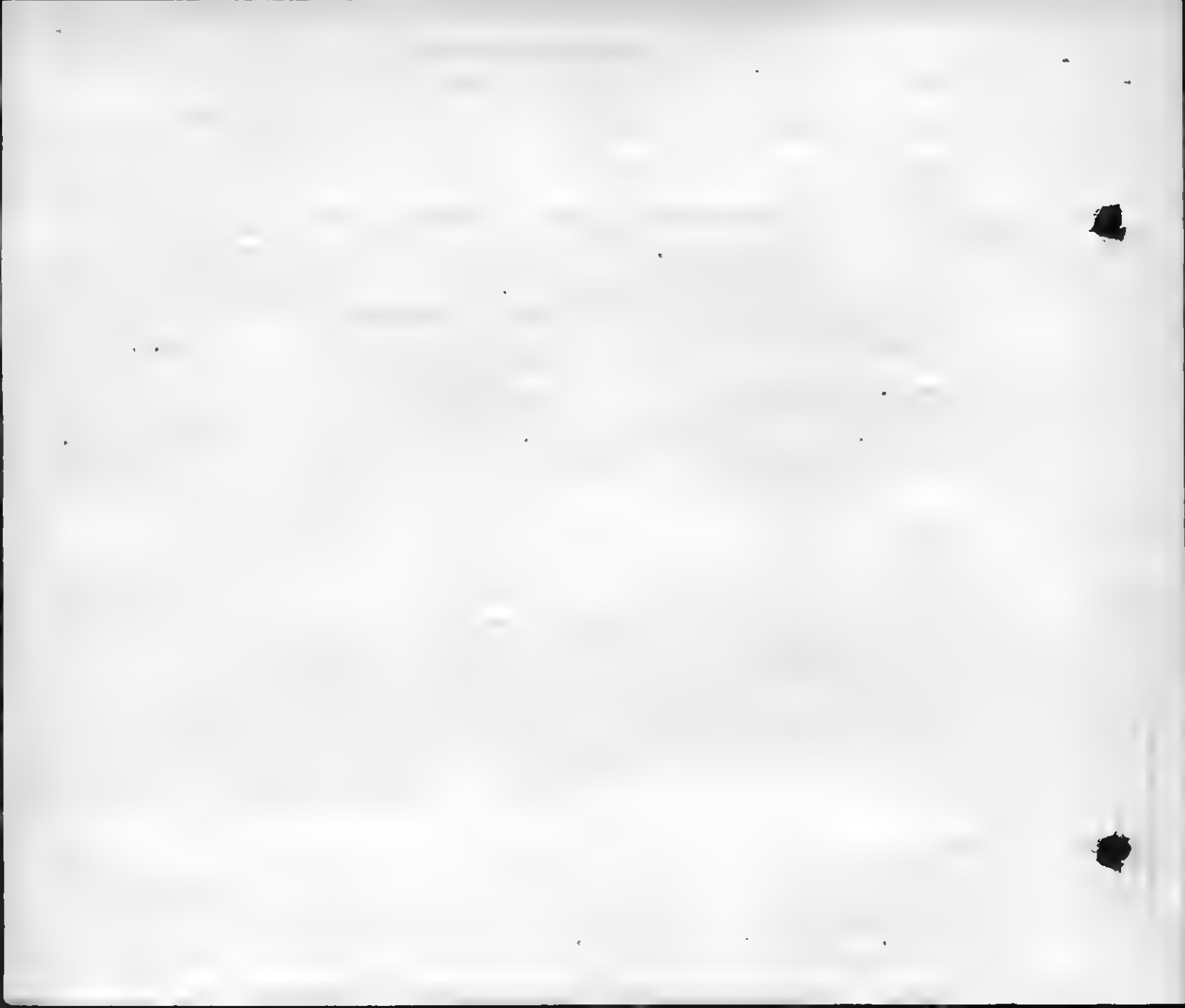
12633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>C.</b> Last <b>Claggett</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/17/00</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles C. Claggett</b>		14. MOTHER'S MAIDEN NAME <b>Cora Allison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Lola A. Claggett</b>		Address <b>Route 2 Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Heart Disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction</b> DUE TO (b) <b>Chronic Heart Disease</b> (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-30-58</b> to <b>11-7-58</b> , that I last saw the deceased alive on <b>11-6-58</b> , and that death occurred at <b>5:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>809 Viers Mill Rd. Rockville, Md.</b> DATE SIGNED <b>11/7/58</b>			
ACTUAL SIGNATURE <b>Herman Maganzini</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Herman Maganzini</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/10/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 58</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12655 CERTIFICATE OF DEATH

12634

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		<b>2. USUAL RESIDENCE</b> (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FRANK</u> Middle <u>J</u> Last <u>CLEMENTS</u> <b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>26</u> Year <u>1958</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept. 21, 1909</u> <b>9. AGE</b> (In years last birthday) <u>49</u> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>cab driver</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self-employed Washington D.C.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Thomas E. Clements</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 2</u> <b>16. SOCIAL SECURITY NO</b> <u>579-22-5051</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Smith</u> <b>17. INFORMANT</b> <u>Med Irene Clements-Burtonsville</u> Address <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma tons</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Carcinoma Stomach</u> DUE TO <u>18 Mos.</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic gastritis</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <u>8/4</u> , 19 <u>58</u> , to <u>11/26</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>11/25</u> , 19 <u>58</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>ACTUAL SIGNATURE</b> <u>J M Warren</u> M.D. <u>Laurel</u> <u>11/28/58</u> <b>PHYSICIAN'S NAME (Type)</b> <u>J M WARREN</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>22b. DATE THEREOF</b> <u>11/28/58</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Mary Cem.</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Laurel Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W H McCallan</u> ADDRESS <u>Laurel Md.</u> <b>24a. REC'D BY REGISTRAR</b> <u>DEC 1 '58</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>	

THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12635

12656

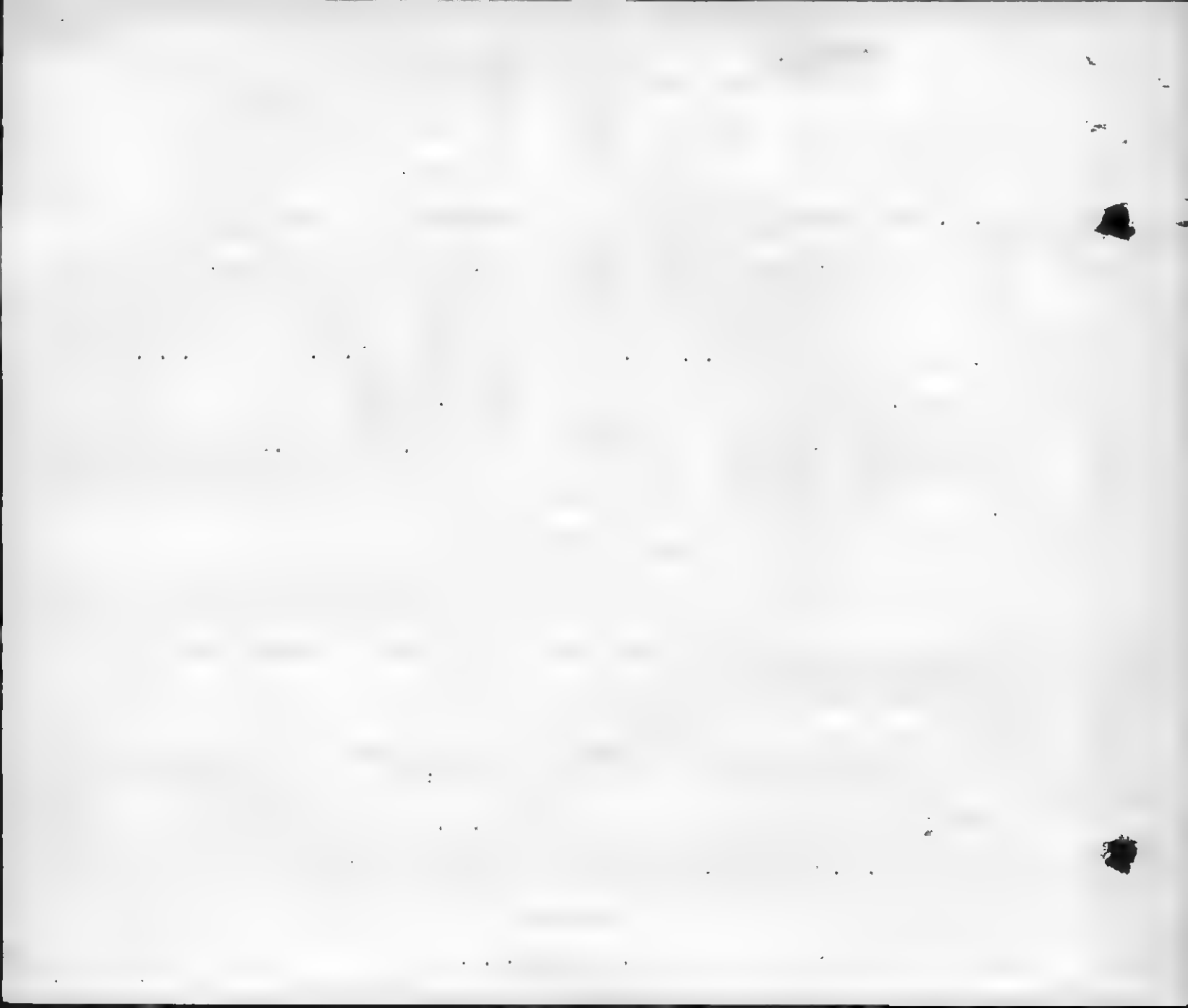
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>5 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>7</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b> d. STREET ADDRESS <b>2H Laurel Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Wallace Alexander CLUBB</b>				4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-1-97</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Govt.</b>			
13. FATHER'S NAME <b>George R. CLUBB</b>				14. MOTHER'S MAIDEN NAME <b>Anna L. NOTHEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>577-20-4772</b>			
17. INFORMANT <b>(S) Wallace A. Clubb, Jr., same as #2 above</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Electrolyte imbalance &amp; uremia</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>November 14, 1958</b> , to <b>November 15, 1958</b> , that I last saw the deceased alive on <b>November 15, 1958</b> , and that death occurred at <b>12:20AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. H. O'Connell</b>				DATE SIGNED <b>11-15-58</b>			
PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LT, MC, USN</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home, 4th &amp; Mass. Ave., NW, Wash.D.C.</b>				24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



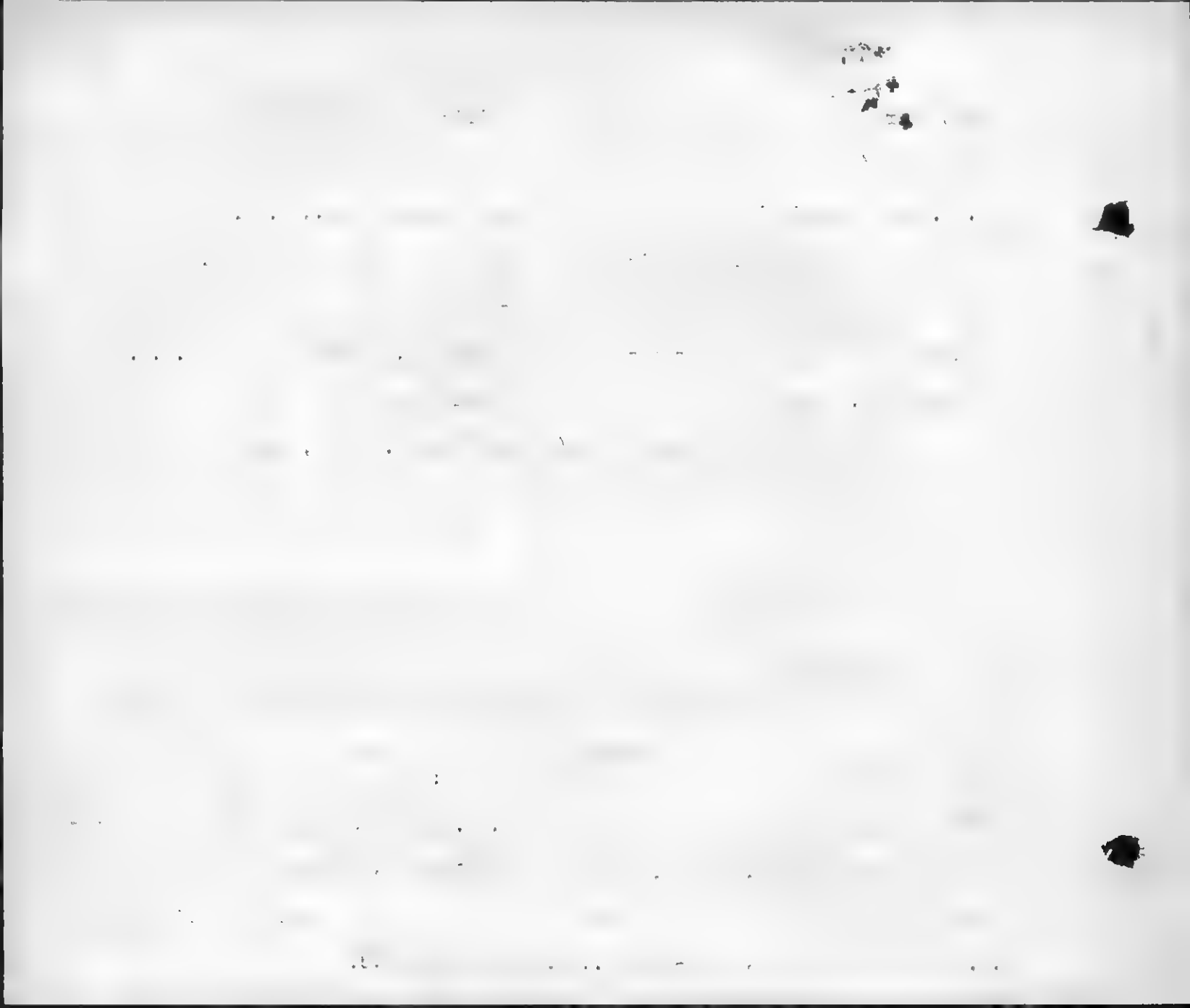
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12057**  
**CERTIFICATE OF DEATH**

12636

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) b. STATE <b>District of Columbia</b> COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			d. STREET ADDRESS <b>2540 Southern Ave., S. E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Enrique Ricardo COBBS</b>			4. DATE OF DEATH Month Day Year <b>November 3 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-1-58</b>		9. AGE (In years last birthday) yrs <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>	
13. FATHER'S NAME <b>Sylvester E. COBBS</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>(F) Sylvester E. Cobbs, same as #2 above</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary Atelectasis</b> 712.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronicity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>47 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>November 1, 1958</b> to <b>November 3, 1958</b> that I last saw the deceased alive on <b>November 3, 1958</b> and that death occurred at <b>5:45A M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>David Harris</b>			DATE SIGNED <b>11-3-58</b>		
PHYSICIAN'S NAME (Type) <b>David HARRIS, LT, MC, USN</b>			ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		24a. REC'D BY REGISTRAR <b>NOV 5 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.H. Bacon Funeral Home, 1722-7th St., NW, Washington, D.C.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



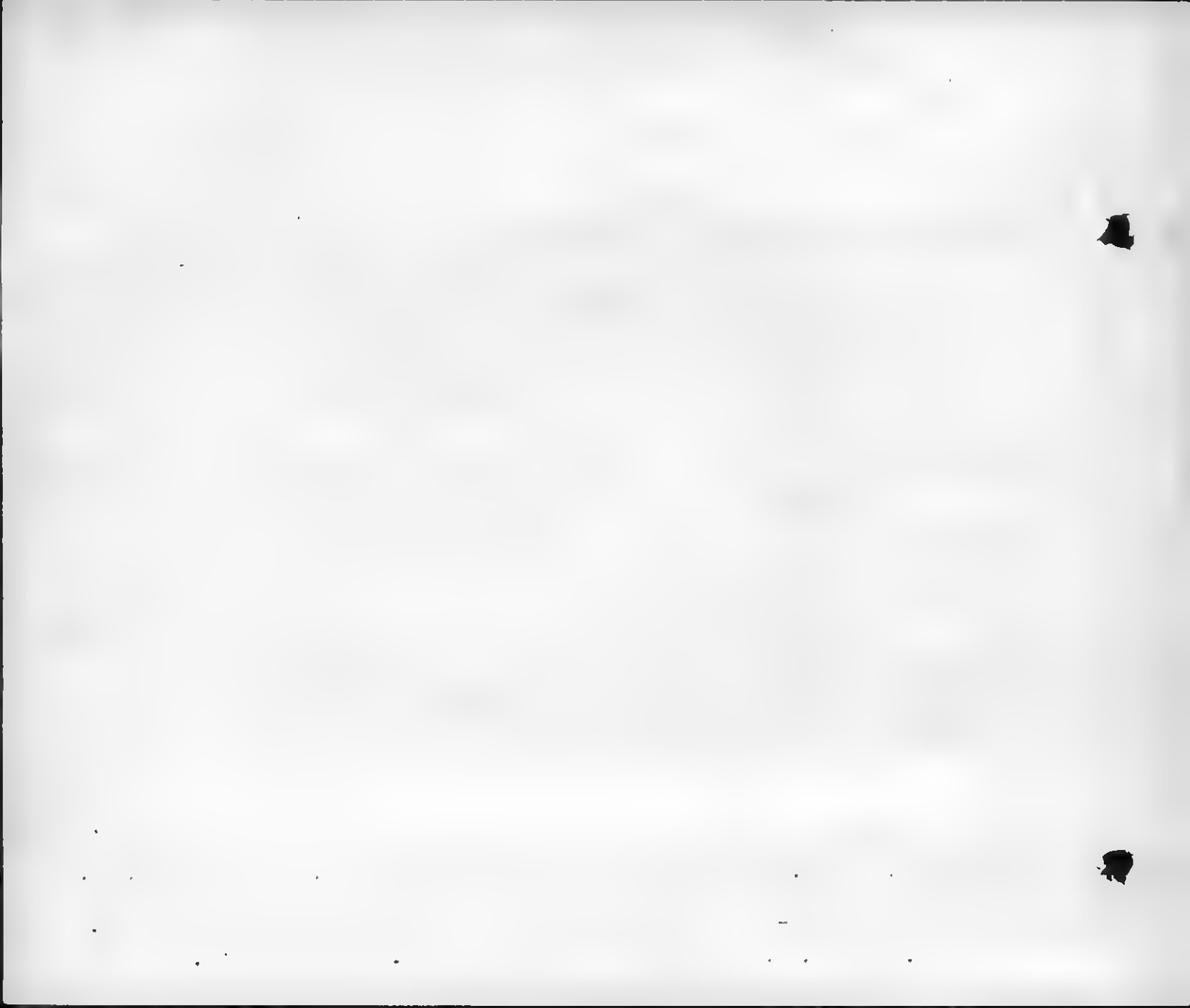
1  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12602**  
**CERTIFICATE OF DEATH**

12637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>10020 Reddick Drive,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cochran</b>		4. DATE OF DEATH Month Day Year <b>November 29, 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 29, 58</b>
9. AGE (In years last birthday) yrs. Months Days <b>24 11 19</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>24 11 19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<b>Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Winston Earl Cochran</b>		14. MOTHER'S MAIDEN NAME <b>Gloria Lee Grimes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>husband</b>	
17. INFORMANT <b>same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>762.5 Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/29, 1958</b> to <b>11/30, 1958</b> , that I last saw the deceased alive on <b>11/30, 1958</b> , and that death occurred at <b>139</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>925 Pershing Dr., Silver Spring, Md.</b>			
ACTUAL SIGNATURE <b>Raymond F. Chinn</b>		M.D. <b>925 Pershing Dr., Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Raymond F. Chinn, M. D.</b>		<b>925 Pershing Dr., Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>11-29-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital</b>	22d. LOCATION (City, town, or county) (State) <b>Takoma Park, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		ADDRESS <b>Washington Sanitarium and Hosp.</b>	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <b>7 2 8 Frank</b>	

2075346XV0





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12058 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
f. STREET ADDRESS <b>1001 Kathryn Road</b>		g. IS RECORD OF ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dudley Harry COLEMAN</b>		4. DATE OF DEATH Month Day Year <b>November 7 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 December 1913</b>
9. AGE (In years last birthday) <b>44 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired TEL USN</b>		12. KIND OF BUSINESS OR INDUSTRY <b>South Carolina</b>	
13. FATHER'S NAME <b>Leslie COLEMAN</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Virginia FOUNTIAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>577 16 7157</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> (c), stating the underlying cause last. (c) <b>420.1</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. BROSCHART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7 November 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-12-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Pumphrey Funeral Home, 8434 Ga. Ave.,</b>		24a. REC'D BY REGISTRAR <b>NOV 12 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12659

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>232 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>Route 1, Box 402B</b>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Collins</b>			4. DATE OF DEATH Month <b>November</b> Day <b>13,</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 17, 1912</b>		9. AGE (In years lost birthday) <b>46 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Jerry Ward</b>			14. MOTHER'S MAIDEN NAME <b>Esther Tuller</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>429-34-3594</b>	17. INFORMANT <b>The Medical Record</b> address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Right Kidney</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>March 26,</b> 19 <b>58</b> , to <b>November 13,</b> 19 <b>58</b> , that I last saw the deceased alive on <b>November 13,</b> 19 <b>58</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>G. Richard Lee</b> M. D. <b>The Clinical Center</b> <b>11-13-58</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland PHYSICIAN'S NAME (Type) <b>G. Richard Lee, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>	22b. DATE THEREOF <b>11/15/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Worthington</b>		22d. LOCATION (City, town, or county) (State) <b>Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>		24a. REC'D BY REGISTRAR <b>Nov 18 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



12603

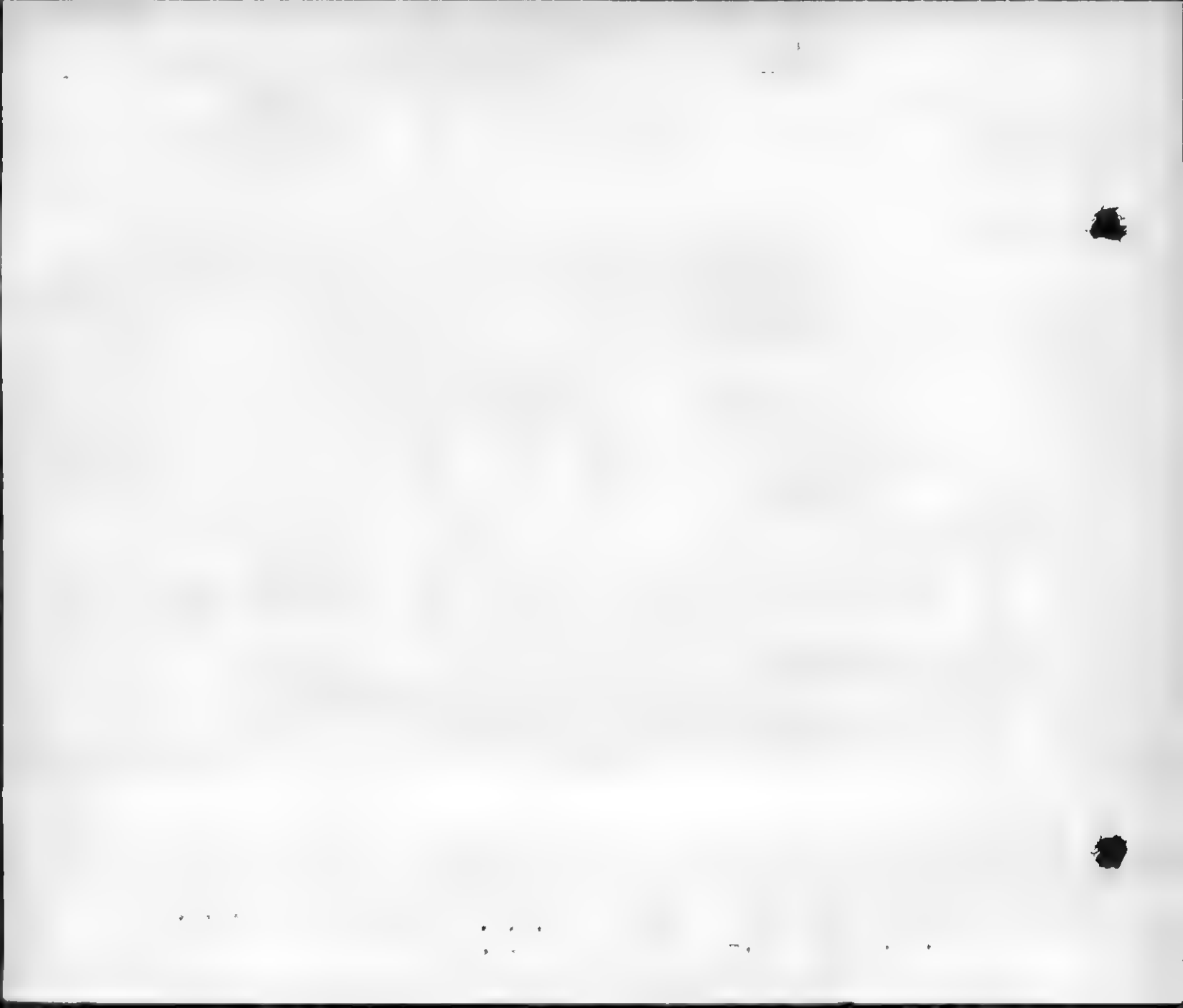
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>2 days 6 hrs.</u>				d. STREET ADDRESS <u>1704 Novels Lane</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington-Silver Spring Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>May</u> Last <u>Connelly</u>				4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/79</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u>21</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>11</u> Hours <u>21</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>David H. Pugh</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>PH's hosp. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>443x</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Jan. 1956</u> to <u>Nov. 1958</u> , that I last saw the deceased alive on <u>Nov. 21, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8901 Ga. av. Silver Spring Md.</u>				DATE SIGNED <u>Nov 24 '58</u>			
ACTUAL SIGNATURE <u>Frank G. Leslie</u>				M.D. <u>8901 Ga. av. Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank G. Leslie</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR <u>Nov 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ernest S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12660

CERTIFICATE OF DEATH

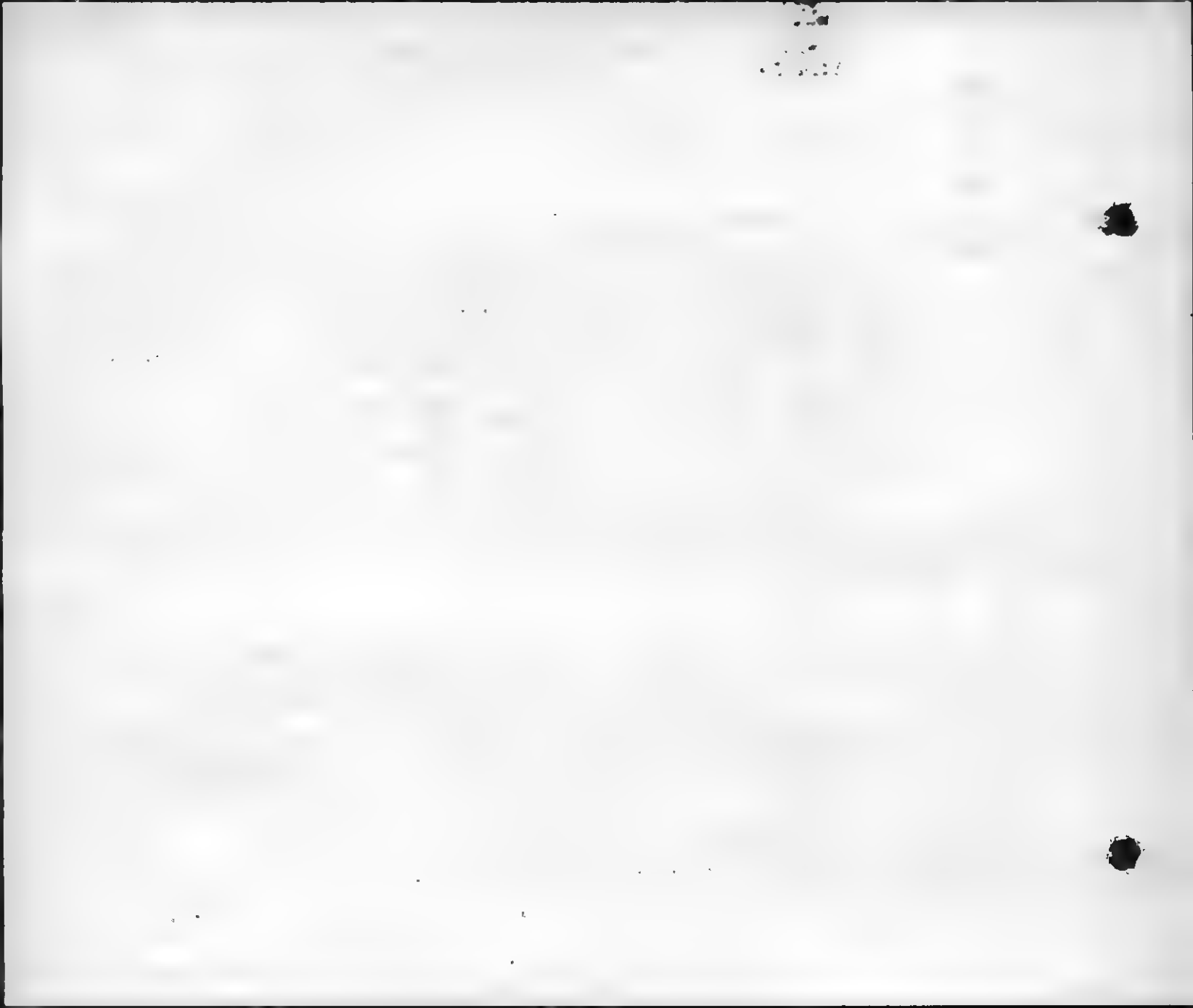
12641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS <b>Gaithersburg</b> <b>Route #2, Box 252</b>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Coplin</b> Last <b>Coplin</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12.8.80</b>	9. AGE (In years last birthday) <b>77 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hezekiah Coplin</b>				14. MOTHER'S MAIDEN NAME <b>Amy Washington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Myocardial Infarction by Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lymphosarcoma</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> 19 <b>58</b> , to <b>Nov. 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov. 9</b> , 19 <b>58</b> , and that death occurred at <b>5:30</b> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jack Schumacher</b>				DATE SIGNED <b>11-9-58</b>			
PHYSICIAN'S NAME (Type) <b>Jack Schumacher, M. D., Gaithersburg, Md.</b>				ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, or other (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove.</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sworden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carroll S. Kenna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12661

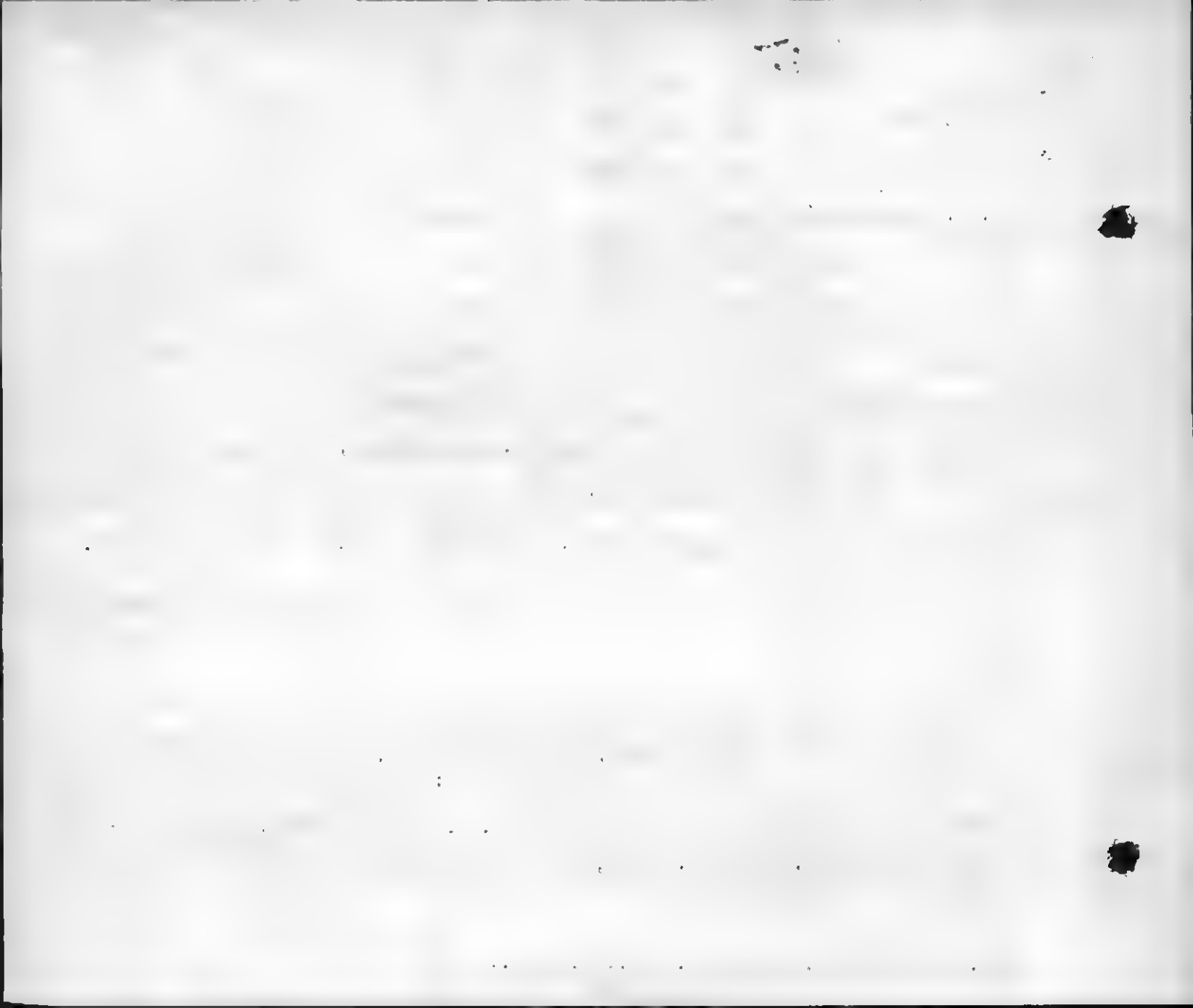
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a COUNTY <b>Montgomery</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>39 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Virginia</b> b COUNTY <b>Quantico</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1958</b>	
3. NAME OF DECEASED (Type or print) First <b>Isis</b> Middle <b>Maria</b> Last <b>CORREA</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-20-52</b>		9. AGE (In years last birthday) yrs. <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Brazil</b>	
12. CITIZEN OF WHAT COUNTRY <b>Brazil</b>		13. FATHER'S NAME <b>Diony CORREA</b>		14. MOTHER'S MAIDEN NAME <b>Elsa RODRIGUES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>(F) Mr. Diony Correa, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>4.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Leukemia, acute, myelomonocytic type</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 mos.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept. 23</b> , 19 <b>58</b> , to <b>Nov. 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>October 31</b> , 19 <b>58</b> , and that death occurred at <b>4:57A</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas E. Cone, Jr.</b> M.D. <b>U. S. Naval Hospital, NMNC</b> <b>11-1-58</b>					
ACTUAL SIGNATURE <b>Thomas E. Cone, Jr.</b> M.D. <b>U. S. Naval Hospital, NMNC</b> <b>11-1-58</b>					
PHYSICIAN'S NAME (Type) <b>Thomas E. CONE, Jr., CAPT, MC, USN Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rio de Janiero Brazil</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawler &amp; Sons</b>		ADDRESS <b>105 Gawler &amp; Sons, 1756 Penn. Ave., NW, Wash., DC</b>		24a. REC'D BY REGISTRAR <b>NOV 3 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Agnes</u> Last <u>Cross</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2.14.95</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY  	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. FATHER'S NAME <u>Albert Thompson</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Thompson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>42 a.m.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decomposition</u> DUE TO (c) <u>chronic Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH  
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/16/58</u> , 19 <u>  </u> , to <u>11/17/58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>11/16/58</u> , 19 <u>  </u> , and that death occurred at <u>5:30 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>L. L. Le</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. I. Leal, M. D.</u> <u>Gaithersburg, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 19</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>	22d. LOCATION (City, town, or county) (State) <u>Howard County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	24a. REC'D BY REGISTRAR <u>NOV 20 58</u>
24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 12 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. STREET ADDRESS <u>13420 Denay Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12420 Denay Rd</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1958</u>	
3. NAME OF DECEASED (Type or print) <u>Edward Daniel Cunningham</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>9-20-58</u>		9. AGE (In years last birthday) <u>1</u> yrs <u>12</u> mos <u>12</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Carl Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Viola Jordan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Viola Cunningham</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475x</u> DUE TO <u>Asphyxia</u>		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Hanes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074276XV2



12664

## CERTIFICATE OF DEATH

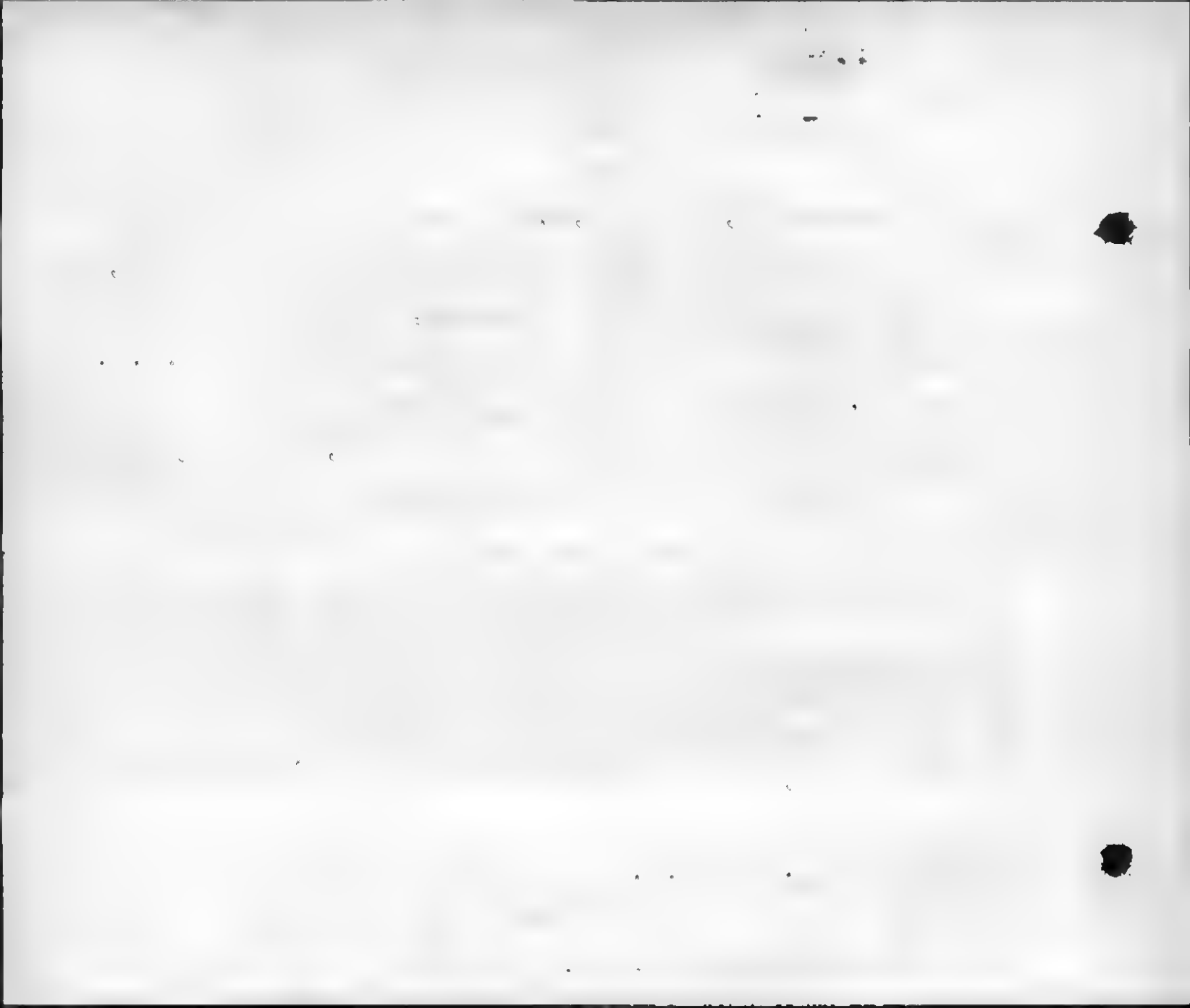
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>55 x 2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middlesboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>209 East Chester Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Elizabeth</u> Last <u>Cunningham</u>				4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1940</u>		9. AGE (In years last birthday) <u>18</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leonard D. Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Inez Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheobronchial Obstruction</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Spontaneous Hemoptysis</u> (c) <u>Congenital Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> <u>2 hours 20min.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 6, 1958</u> to <u>November 30, 1958</u> , that I last saw the deceased alive on <u>November 30, 1958</u> and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>11/30/58</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>William W. Pfaff</u> M.D.				PHYSICIAN'S NAME (Type) <u>William W. Pfaff, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cawood Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Middlesboro Ky.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home 4812 Ga. Ave. N.W.</u>				24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. 8. 11/58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12604

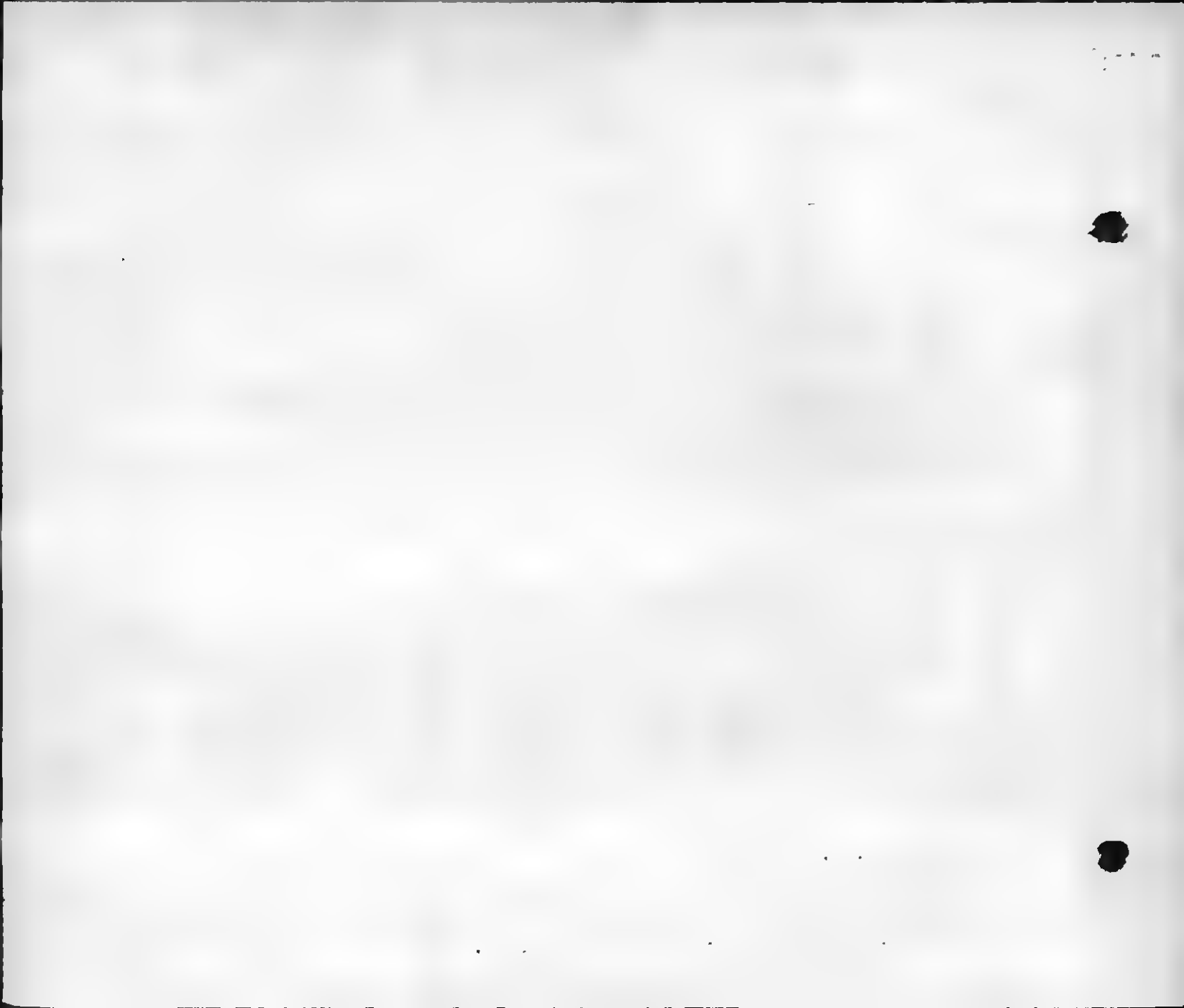
**CERTIFICATE OF DEATH**

12646

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>17 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MONTGOMERY</u> <span style="float:right">b. COUNTY <u>MONTGOMERY</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10203 Ridgemoor Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Daisy Isola Dankmeyer</u> <b>4. DATE OF DEATH</b> Month Day Year <u>Nov. 19 1958</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Wh</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6-16-73</u> <b>9. AGE</b> (In years last birthday) <u>85</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>		<b>13. FATHER'S NAME</b> <u>George Taylor</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah J. Dankmeyer</u> <span style="float:right">HANEY</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> YES <input checked="" type="checkbox"/> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>—</u> <b>17. INFORMANT</b> <u>Chart &amp; Family</u> <span style="float:right">Address</span>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic valvular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I attended the deceased from</b> <u>Aug. 1952</u> <b>to</b> <u>Nov. 19 1958</u> , <b>that I last saw the deceased alive on</b> <u>Nov. 19 1958</u> , <b>and that death occurred at</b> <u>3:10 P.M.</u> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>A. L. Thibadeau</u> <span style="float:right">ADDRESS (Street, city or town, state) DATE SIGNED</span> <b>PHYSICIAN'S NAME (Type)</b> <u>A. L. THIBADEAU</u> <span style="float:right"><u>10111 Colasville Rd</u> <u>Silver Spring, Md.</u></span>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>11/22/58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PAPKLAWN CEMETERY</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u> (State) _____		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Ziska</u> <span style="float:right">ADDRESS <u>SILVER SPRING, MD.</u></span> <b>24a. REC'D BY REGISTRAR</b> <u>Nov 24 58</u> <span style="float:right">DATE</span> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Robert A. ...</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12605 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12647

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San Y Hospital</u>				d. STREET ADDRESS <u>2620 Kirkwood Pl.</u>			
3. NAME OF DECEASED (Type or print) <u>James T DeLonge</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>17</u> - Year <u>58</u>			
5. SEX <u>m.</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1 - 58</u>		9. AGE (In years last b. day) yrs <u>3</u> Months <u>16</u>		IF UNDER 24 HRS Hours <u>16</u> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chippewa Falls, Wisc.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Mr. Roland J. DeLonge</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ann Olson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mr. Roland J. DeLonge</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respir. Infection</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>5 m. dead in bed</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-17-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Transportation Nov 19, 1958</u>		<u>Bloomer</u>		<u>Wisconsin</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12665 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

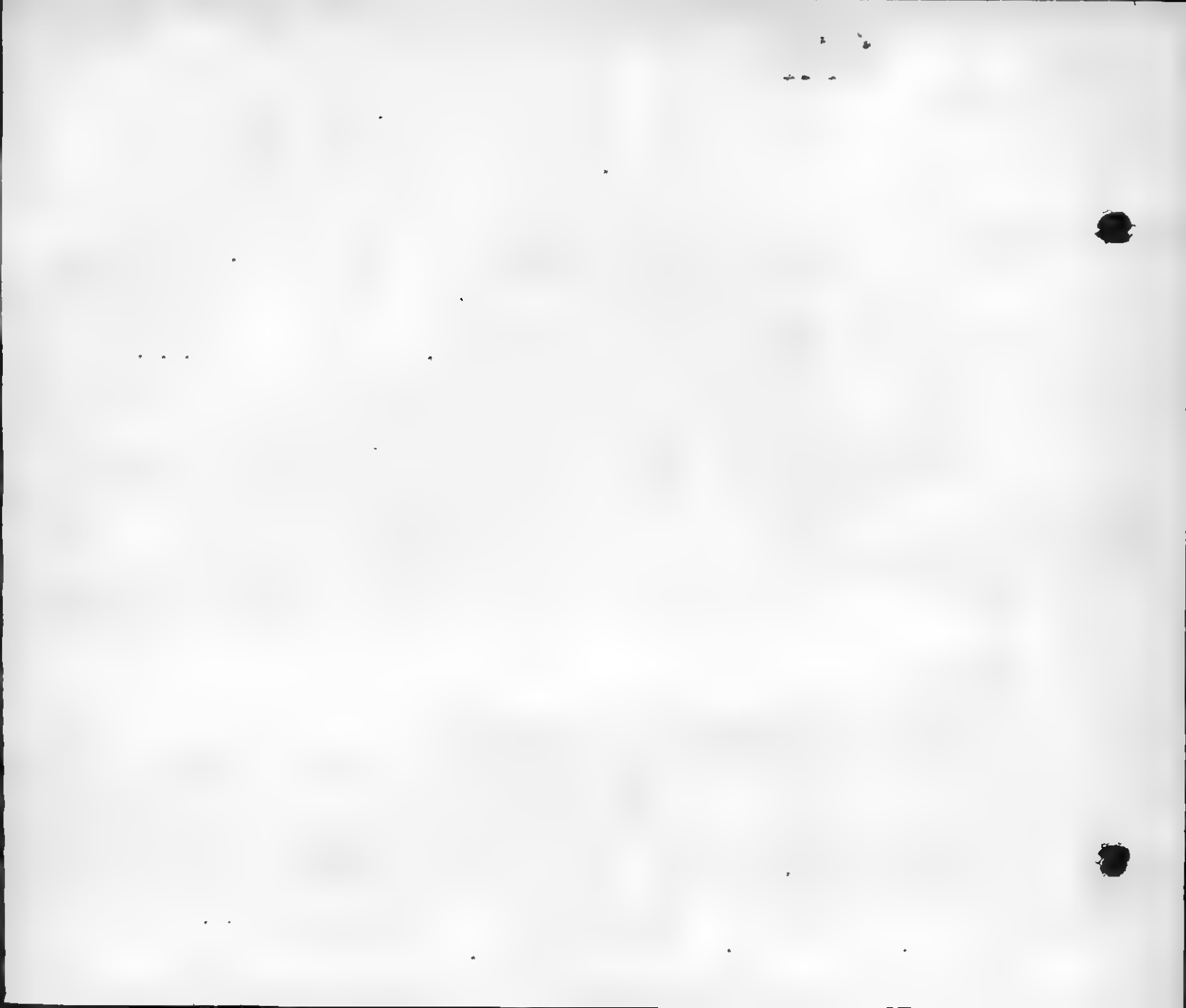
12648

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b> c. LENGTH OF STAY IN 7b <b>4 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8804 WALNUT HILL ROAD</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b> / d. STREET ADDRESS <b>8804 WALNUT HILL ROAD</b> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edwin Porter Denslow also known as Edwin Porter Brereton</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/29/88</b>	
9. AGE (in years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>		12. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed - never worked</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Conn.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>LeGrand Norton Denslow</b>				14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Annelee Connors - Same Item 2</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>11/24/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. Raymond A. Zick</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>11/26/58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			



12666

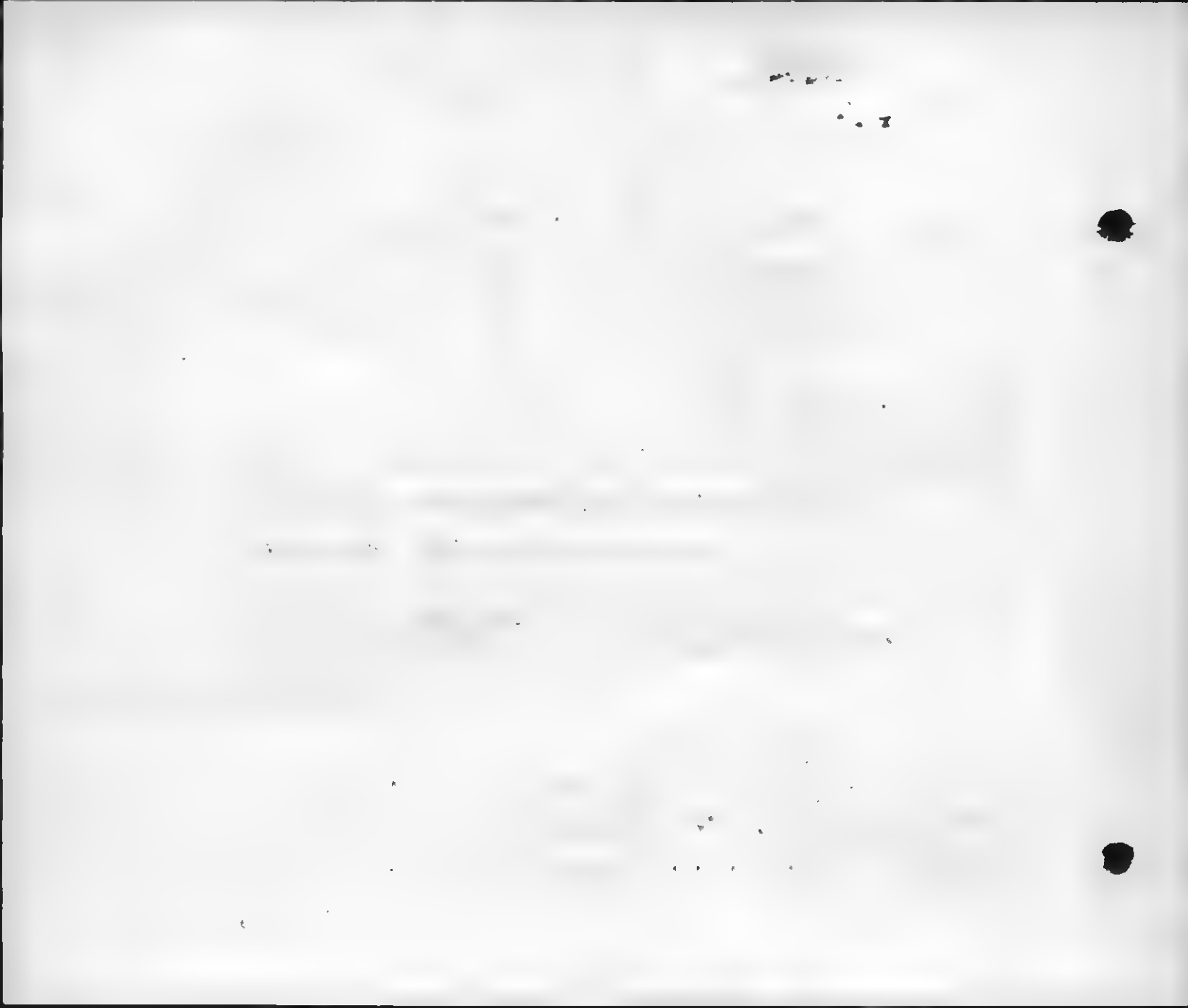
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>38 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> d. STREET ADDRESS <b>114 East Greenway Boulevard</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marion (none) Dhein</b>				4. DATE OF DEATH Month Day Year <b>November 6, 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1899</b>	
9. AGE (In years last birthday) <b>59 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Donald C. MacPherson</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Graham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-28-5186</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X necrotizing pneumonia lt lung</b> DUE TO (b) <b>Carcinoma of the breast</b> DUE TO (c) <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>massive liver metastases</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 29, 1958</b> to <b>November 6, 1958</b> , that I last saw the deceased alive on <b>November 6, 1958</b> and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>7/11/1958</b> ACTUAL SIGNATURE <b>Richard H. Moy</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Richard H. Moy, M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>11/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawkins</b>				ADDRESS <b>1756 Pa. Ave. NW</b>		24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. E. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12621

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12650

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen Mill Rd.</u>		d. STREET ADDRESS <u>/ Glen Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> <u>Dillard</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> , Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/76</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ill.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Winkelman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Puckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Josiah Dillard</u>		Address <u>Same as item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o m <u>  </u> p m. <u>  </u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>Nov. 28, 1958</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12667

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Pittsylvania</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>134</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>Marvin</u> Last <u>Dowdy</u>				4. DATE OF DEATH Month <u>November</u> Day <u>1<sup>st</sup></u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1902</u>	
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> M'n <u>  </u>			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Walter T. Dowdy</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. West</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>Unavailable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleeding, Site undetermined</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hodgkin's disease (Hepatic involvement)</u> DUE TO (c) <u>Pseudomonas Septicemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4</u> days <u>14</u> Mo. <u>10</u> days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 7, 1958</u> to <u>November 18, 1958</u> , that I last saw the deceased alive on <u>November 18, 1958</u> , and that death occurred at <u>1:30A M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>James M. Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/18/58</u>			
PHYSICIAN'S NAME (Type) <u>James M. Marsh, M.D.</u>				ADDRESS <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Altavista, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wheatley Funeral Home</u> <u>By Ruth D. Dwyer</u>				ADDRESS <u>809 King St. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 20 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

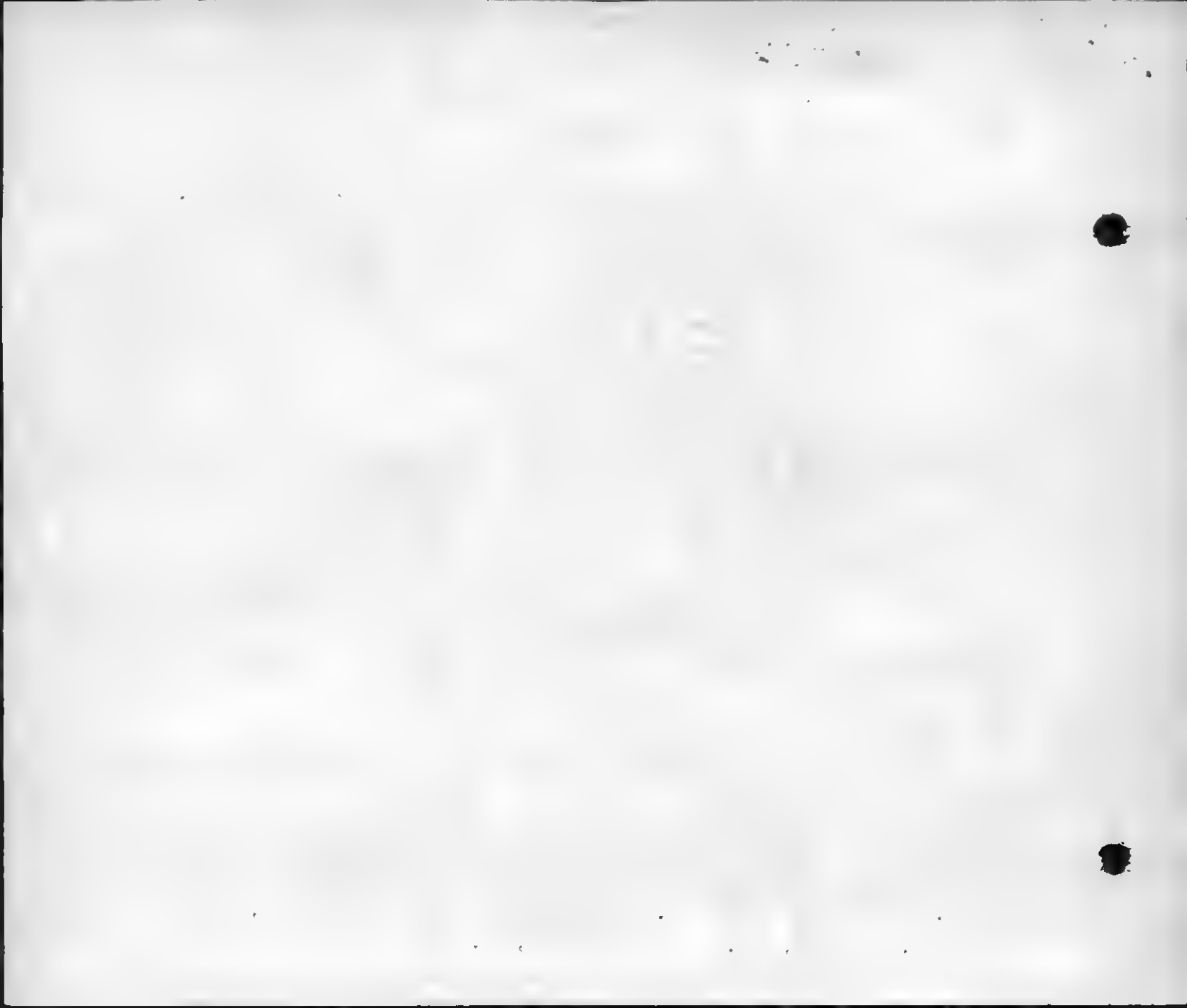
12652

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2316 Blue Ridge Ave.</u>		e. STREET ADDRESS <u>2302 Blue Ridge Ave.</u>	
3. NAME OF DECEASED <u>ESTHER</u> First Middle Last <u>Esther Elmore Draper</u>		4. DATE OF DEATH <u>11-14-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Irvin Pitts</u>		14. MOTHER'S MAIDEN NAME <u>Raymond Draper</u> unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Raymond Draper</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>10.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>DEER CREEK, ILLINOIS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



12669

## CERTIFICATE OF DEATH

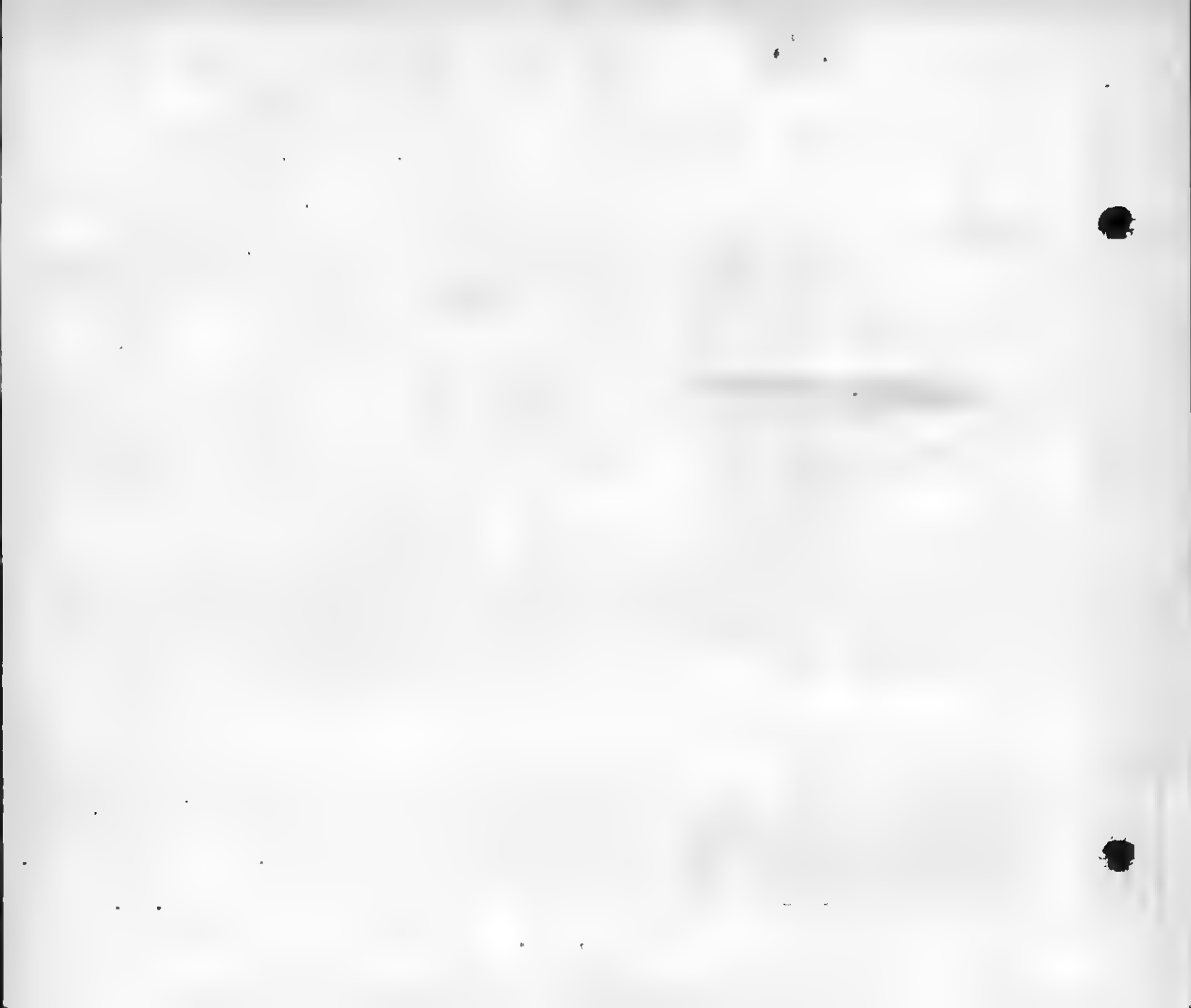
12653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>12 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Suburban Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Washington</b>	
3. NAME OF DECEASED (Type or print) First <b>Henrietta</b> Middle <b>Barber</b> Last <b>Ellis</b>		d. STREET ADDRESS <b>4701 Conn. Ave. N.W.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1874</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>7</b> Days <b>22</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eckert J. Sacks</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Barber Loebischer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George A. Sacks</b>		Address <b>5517 Pembroke Rd. Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO <b>Acute intestinal obstruction,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>cause undetermined</b> DUE TO <b>cause undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right hemiparesis, cerebral aphasia due to old cerebrovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 AM - 8 AM,</b> <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 26, 1958</b> to <b>Nov. 26, 1958</b> , that I last saw the deceased alive on <b>Nov. 26, 1958</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>104 Chevy Chase Dr. Chevy Chase, Md.</b> DATE SIGNED <b>11/26/58</b>	
ACTUAL SIGNATURE <b>George A. Sacks Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>George A. Sacks Jr. M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 28 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>C. A. 2. 11/26/58</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12670

CERTIFICATE OF DEATH

12654

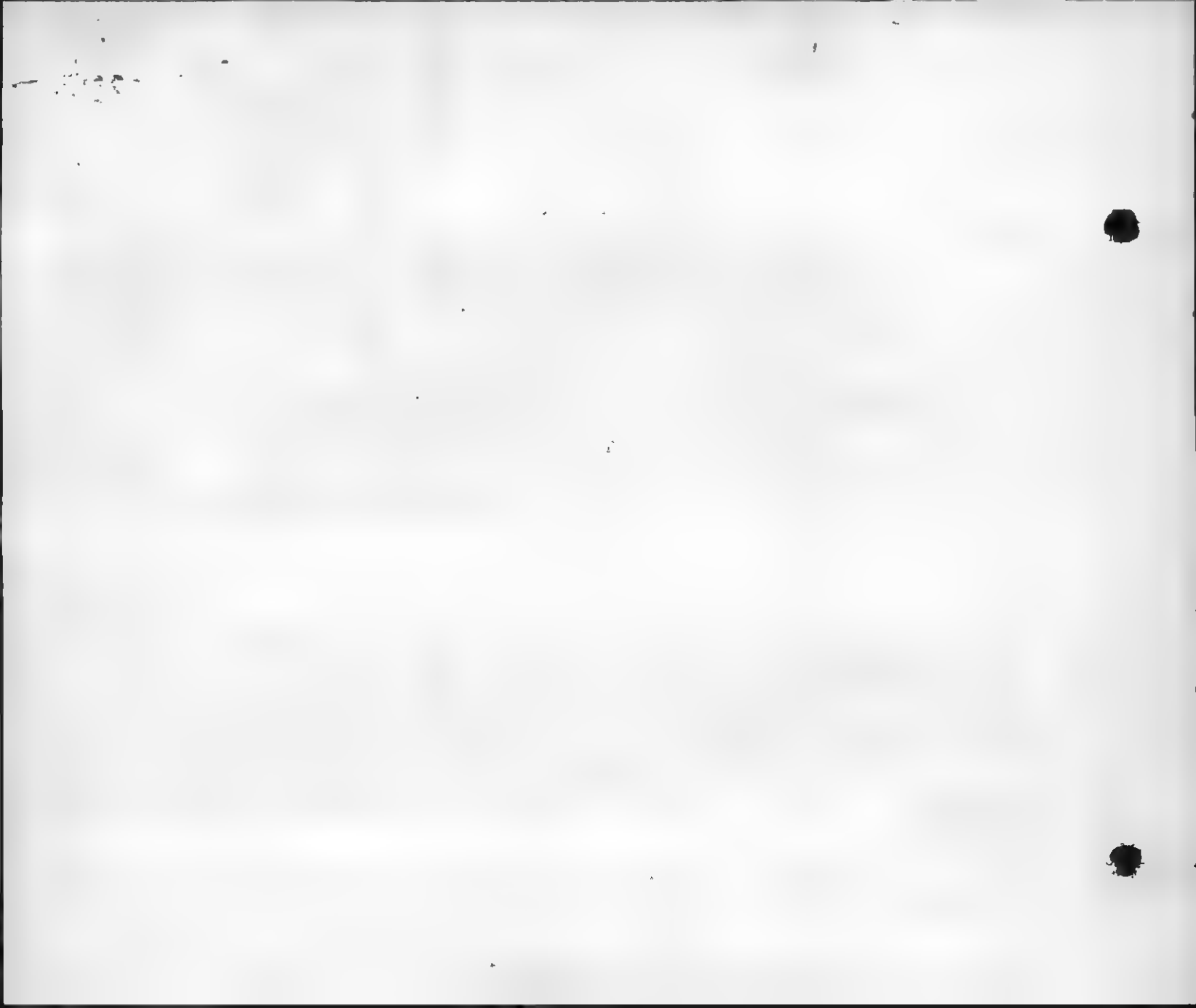
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10602 Amburst Dr</i>		d. STREET ADDRESS <i>10602 Amburst Dr</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>ABRAHAM H ELSBERG</i>		4. DATE OF DEATH Month Day Year <i>NOV 17 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4 - 1908</i>
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Store Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore MD</i>	
11. BIRTH PLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel (Deceased)</i>		14. MOTHER'S MAIDEN NAME <i>Julia Kleinman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>215-053694</i>	
17. INFORMANT <i>Morris Galsberg</i>		Address <i>Arlington Va</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension (longtime)</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Paralytic stroke (hemiplegia) since Feb. 1958</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1958</i> to <i>Nov. 17, 1958</i> , that I last saw the deceased alive on <i>Nov 17, 1958</i> , and that death occurred at <i>10:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John N. Andrews</i>		ADDRESS (Street, city or town, state) <i>9601 Colesville Rd Silver Spring Md</i>	
DATE SIGNED <i>11-17-58</i>			
PHYSICIAN'S NAME (Type) <i>John N. Andrews M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/18-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Two Loash Memorial Park</i>	22d. LOCATION (City, town, or county) (State) <i>Hyattsville Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash. DC</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>Nov 18 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







12672

## CERTIFICATE OF DEATH

12656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3604 Spring Street</b>				d. STREET ADDRESS <b>3604 Spring Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ANN</b> Middle <b>SUTHERLAND</b> Last <b>EVANS</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 5, 1877</b>		9. AGE (In years last birthday) yrs. <b>81</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John Crissy</b>				14. MOTHER'S MAIDEN NAME <b>Sally Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Nancy Blair-daughter-same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerotic cardiovascular disease</b> years DUE TO (c) <b>-----</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
				20f. (City or town) <b>-----</b>		(County) (State)	
21. I certify that I attended the deceased from <b>October, 1956</b> , to <b>November, 1958</b> , that I last saw the deceased alive on <b>November 3, 1958</b> , and that death occurred at <b>7:54 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1834 Eye St. N.W., Washington, D.C.</b> DATE SIGNED ACTUAL SIGNATURE <b>George C. Buchanan</b> M.D. PHYSICIAN'S NAME (Type) <b>George C. Buchanan</b> <b>7822 Custer Road, Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leesburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 3 should be filed with the registrar.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12673

CERTIFICATE OF DEATH

12657

Reg. Dist. No.

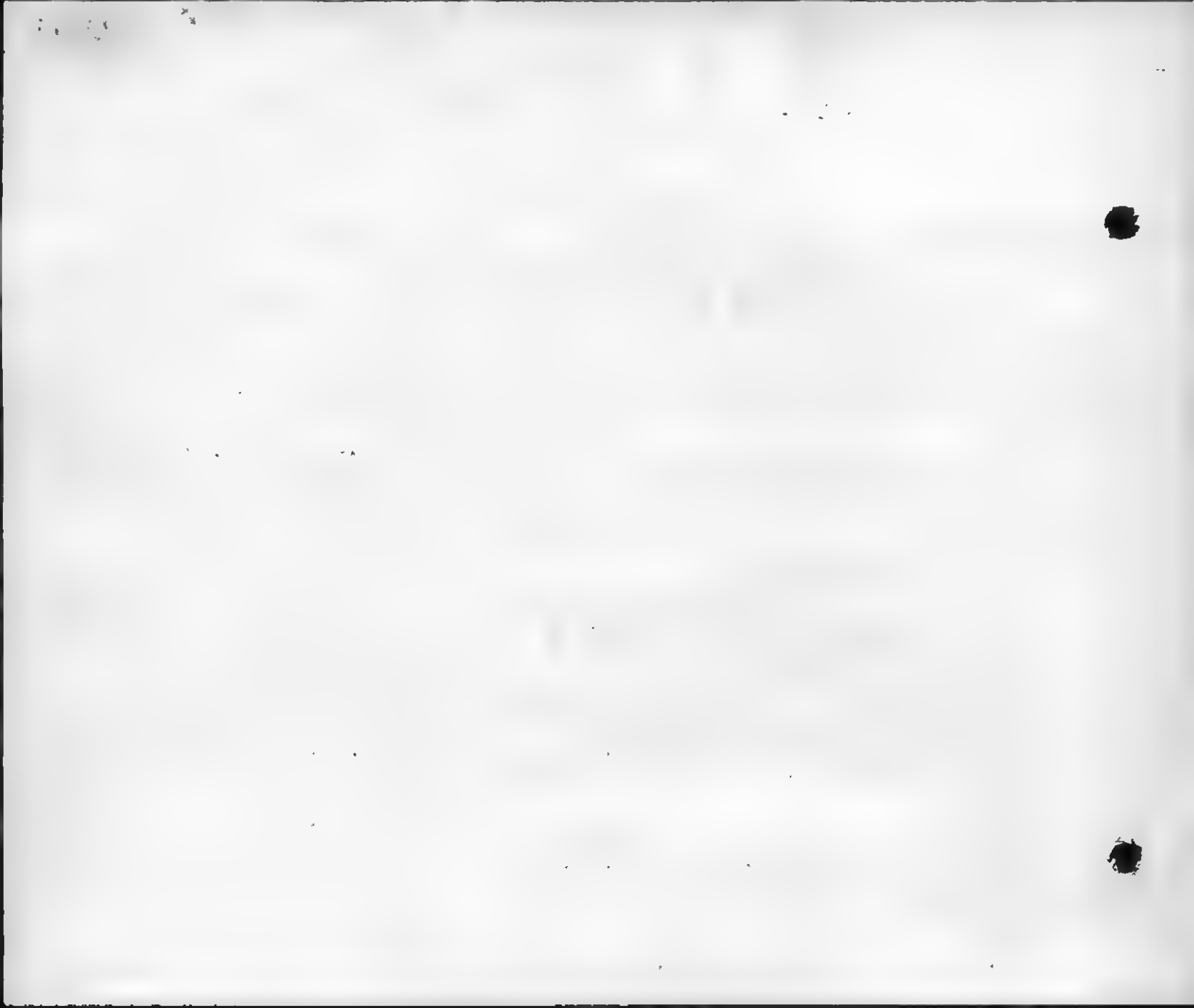
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Rochester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>76 Burrows Hills Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Floyd</b> Last <b>Fairbanks</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 28, 1951</b>
9. AGE (In years last birthday) <b>7</b> yrs		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Carroll H. Fairbanks</b>		14. MOTHER'S MAIDEN NAME <b>Marjorie O. Speaker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Soft ventricular dilatation &amp; cardiac arrest</b> DUE TO <b>4.5</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Congenital heart disease—mitral regurgitation</b> DUE TO (c) <b>Chronic congestive failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b></b> Day <b></b> Year <b>19</b> Hour <b></b> a. m. <b></b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 8, 1958</b> , to <b>November 5, 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> , and that death occurred at <b>3:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William W. Pfaff</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William W. Pfaff, M. D.</b>		DATE SIGNED <b>11/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>11/8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Williamson, New York</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	c. LENGTH OF STAY IN 1b <u>6 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hosp.</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Henry</u> Last <u>Filling</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-93</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn.</u>	11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>
13. FATHER'S NAME <u>Frank Ernest Filling</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Mae Forrest</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Nellie M. Filling, Glenwood, Md.</u>	
17. INFORMANT <u>Nellie M. Filling, Glenwood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 3, 1958</u> to <u>Nov. 9, 1958</u> , that I last saw the deceased alive on <u>November 9, 1958</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u> DATE SIGNED <u>11-10-58</u>	
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>		24a. REC'D BY REGISTRAR <u>NOV 14 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



12606

## CERTIFICATE OF DEATH

12659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o STATE <i>md</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN IB <i>14 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington-Sinclair Memorial Hospital</i>				1 d. STREET ADDRESS <i>11810 Galt Ave</i>			
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Louise</i> Last <i>Flanagan</i>				4. DATE OF DEATH Month <i>November</i> Day <i>25</i> Year <i>1958</i>			
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-11-80</i>	9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Louis Schulte</i>				14. MOTHER'S MAIDEN NAME <i>Fredericka Redenzil</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>pl chart - pt</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma head of pancreas</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes Mellitus</i> DUE TO (c) <i>Nephrotic Syndrome with terminal uremia</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <i>157X</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Feb 20</i> , 1958, to <i>Nov 25</i> , 1958, that I last saw the deceased alive on <i>Nov 24</i> , 1958, and that death occurred at <i>4:02 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Philip C. Jones</i>				ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring, Md.</i>			
PHYSICIAN'S NAME (Type) <i>PHILIP E. JONES</i>				DATE SIGNED <i>11-25-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11/26/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (City, town or county) (State) <i>PRINCE GEO. COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond W. Ziska</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>NOV 26 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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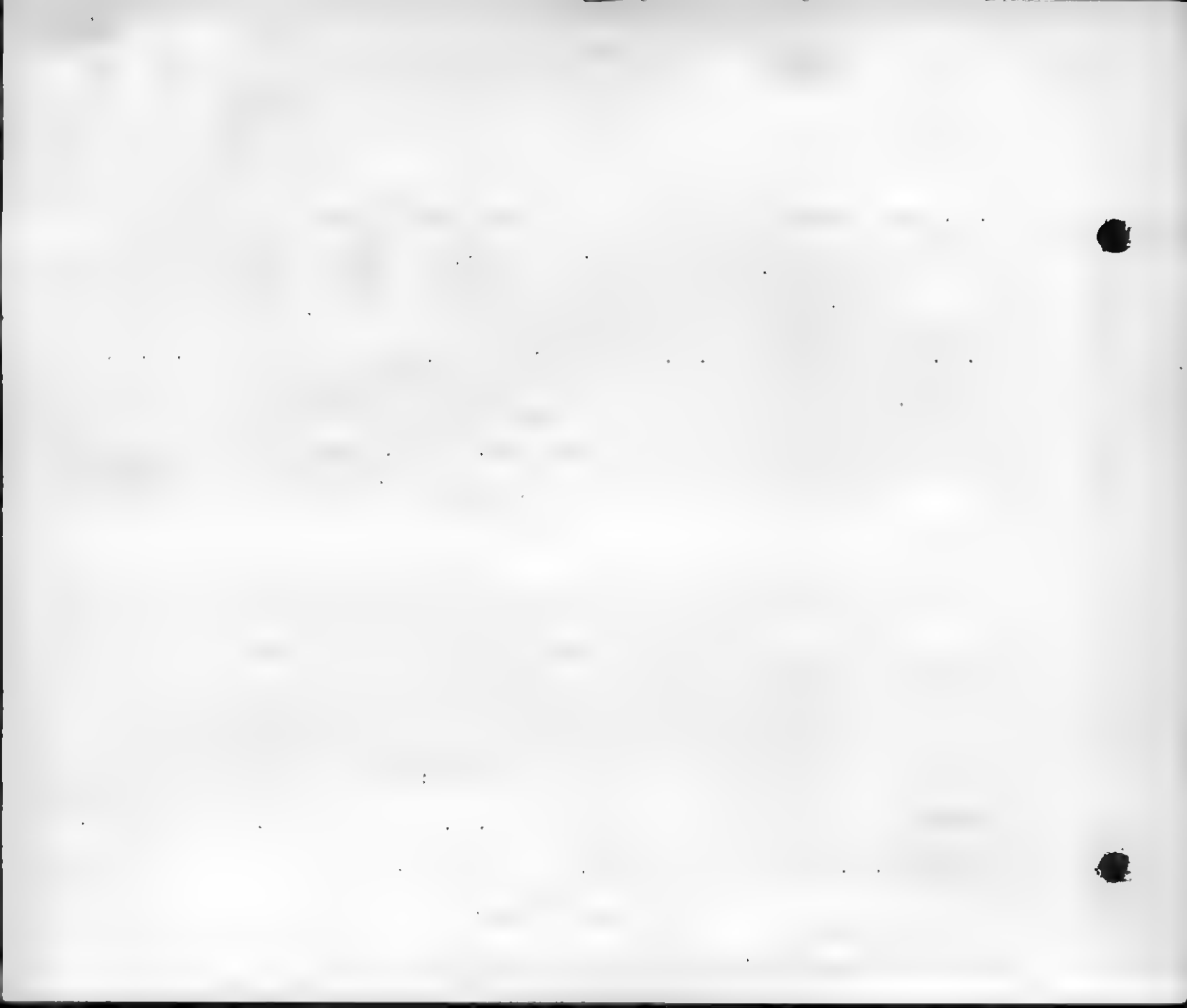
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Annandale</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annandale</b> d. STREET ADDRESS <b>2014 Bradford Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Robert FOSTER</b>		4. DATE Month <b>November</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-04</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Marine Corps</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph R. FOSTER</b>		14. MOTHER'S MAIDEN NAME <b>Antoinette KOEBICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1926 to 1956</b>	
17. INFORMANT <b>(W) Mrs. Ruth M. Foster, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 20, 1958</b> , to <b>November 24, 1958</b> , that I last saw the deceased alive on <b>November 24, 1958</b> , and that death occurred at <b>11:06 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NMMC</b> <b>11-25-58</b>			
ACTUAL SIGNATURE <b>J. T. Horgan</b>		M.D. <b>U. S. Naval Hospital, NMMC</b>	
PHYSICIAN'S NAME (Type) <b>J. T. HORGAN, LCDR, MC, USN</b>		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Everly Funeral Home, 214 W. Main St., Fairfax, Va</b>		24a. REC'D BY REGISTRAR <b>Nov 28 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Orlinda L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12676

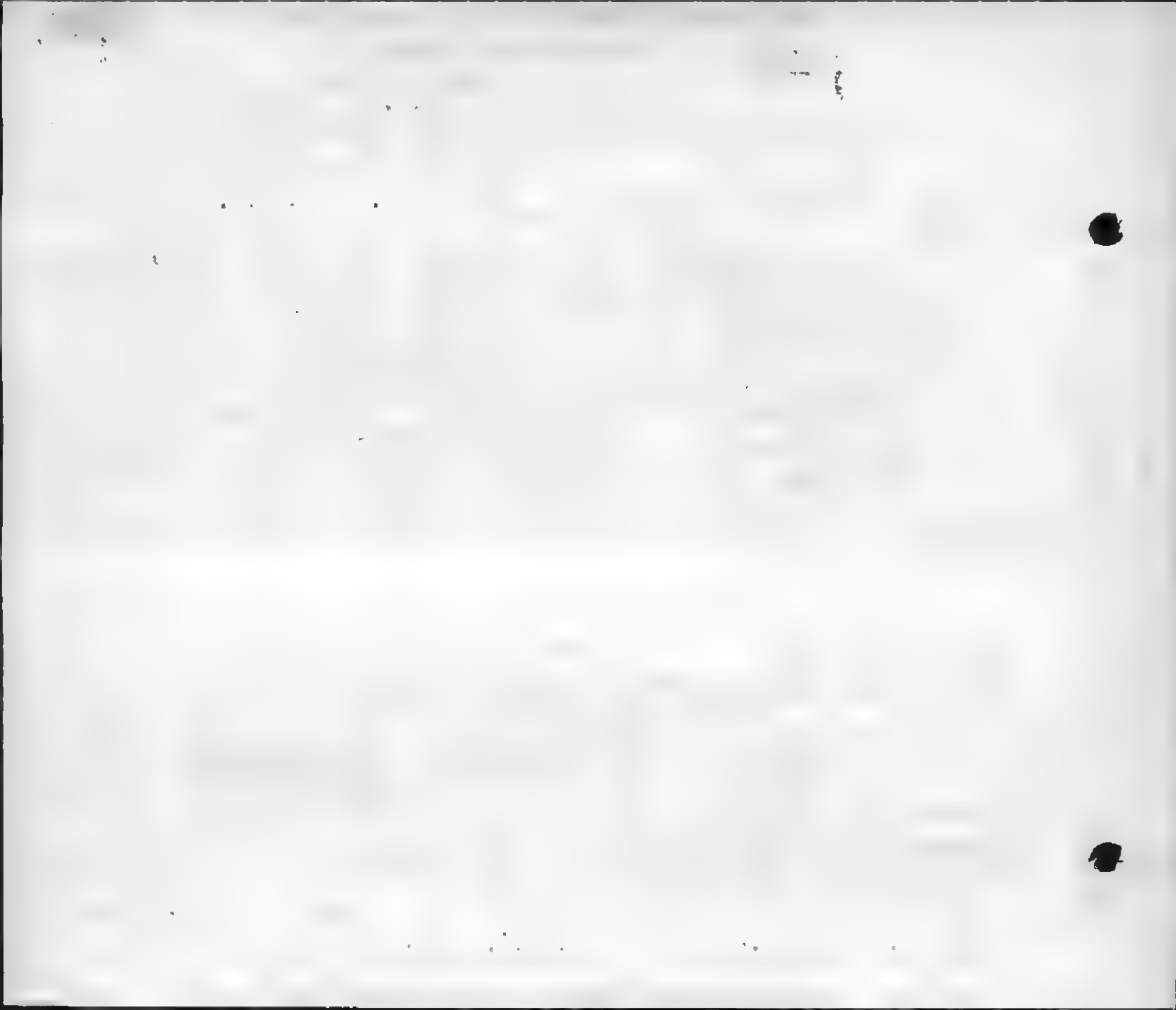
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> <b>5721 Grosvenor Lane</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmor Sanitarium &amp; Hospital</b>				d. STREET ADDRESS <b>4000 Mass. Ave., N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>FOSTER</b> Last				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/18/1875</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Proprietor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph Malloy Foster</b>				14. MOTHER'S MAIDEN NAME <b>Talitha Jameson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <b>5721 Grosvenor Lane</b> <b>Home Records - Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carotid Artery Thrombosis</b> DUE TO <b>Arterio-sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary Artery Disease</b> DUE TO <b>Coronary Artery Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>104 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>6/11/58</b> , 19 <b>19</b> to <b>11/20/58</b> , 19 <b>19</b> , that I last saw the deceased alive on <b>11/20/58</b> , 19 <b>19</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4545 Conn Ave NW Wash DC</b> DATE SIGNED <b>James A. O'Keefe</b>							
ACTUAL SIGNATURE <b>James A. O'Keefe</b> M.D.				PHYSICIAN'S NAME (Type) <b>James A. O'Keefe</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lasting Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Carters Creek, Tennessee</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St., N.W.</b>				24a. REC'D BY REGISTRAR <b>NOV 24 58</b>		24b. REGISTRAR'S SIGNATURE <b>William J. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12662

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>127 Lexington Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>NMN</u> Last <u>Frank</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>24</u> Year <u>19 58</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-84</u>
9. AGE (in years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Simon Fisher</u>		14. MOTHER'S MAIDEN NAME <u>KAROL FISH</u> <u>KAROLINE FISHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Chart</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull fracture &amp; subdural hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Multiple contusions and lacerations of the brain</u> (c) <u>Massive left hemothorax &amp; rib fractures</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Pedestrian struck by auto</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-24-1958</u> Hour <u>2:11</u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BOSCHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KENSICO CEMETERY</u>		22d. LOCATION (City, town, or county) <u>VALHALLA, NEW YORK</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> <u>Raymond G. Zuck</u>		24a. REC'D BY REGISTRAR <u>NOV 26 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krand</u>		DATE <u>11-25-58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

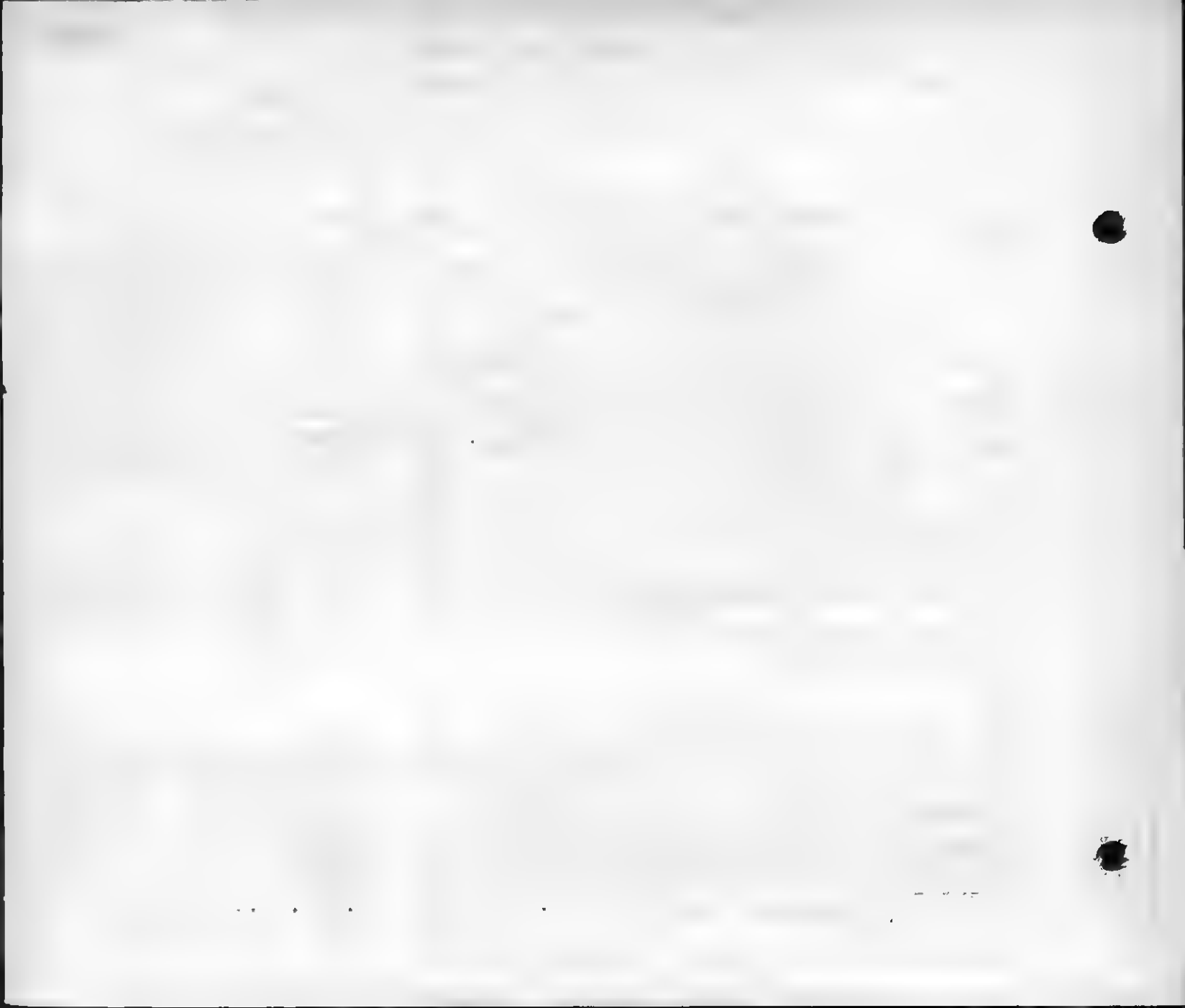
Reg. Dist. No.

12663

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co. Tolson Park MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>Ind. Madison</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Earl</i> Last <i>French</i>				4. DATE OF DEATH Month <i>November</i> Day <i>2</i> Year <i>1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-4-1892</i>	9. AGE (In years last birthday) <i>66</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Architect</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ship Design.</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Christie Fenstermaker</i>				14. MOTHER'S MAIDEN NAME <i>Minerva Adams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>Grace B. French, same as above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia.</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis.</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>2 months.</i> <i>2 years.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Sept. 28, 1958</i> , to <i>Nov. 2, 1958</i> , that I last saw the deceased alive on <i>Nov. 2, 1958</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C. W. Humphreys, Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>1746 K St. N.W.</i>		DATE SIGNED <i>11/3/58</i>	
PHYSICIAN'S NAME (Type) <i>C. W. Humphreys, Jr.</i>				<i>Washington D.C.</i>			
22a. BURIAL, CREMATION, or other disposition		22b. DATE THEREOF <i>11/5/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>George Wash. Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co. 2901-14th St.</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12677

## CERTIFICATE OF DEATH

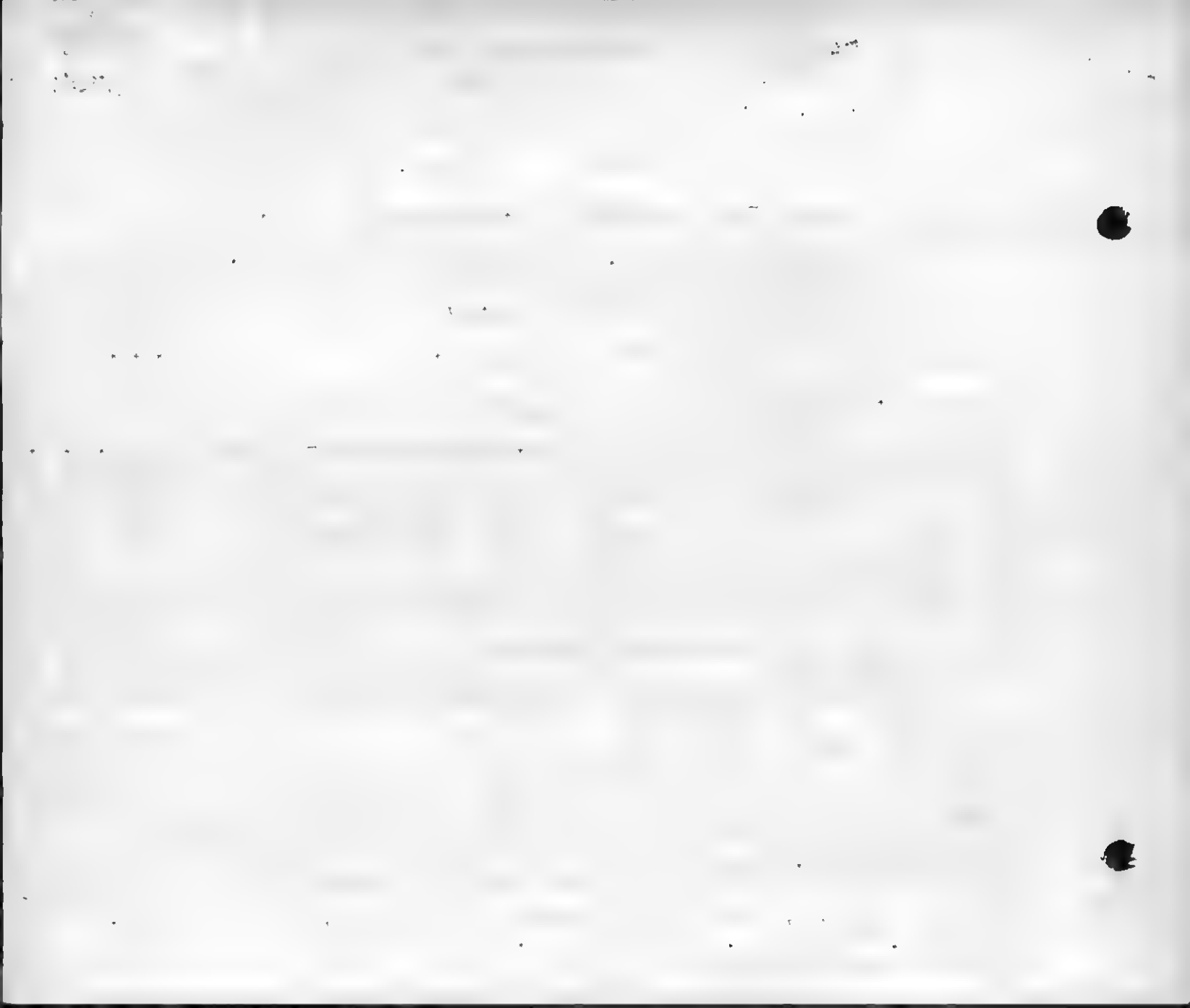
12664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Green's Nursing Home - 14326 Collesville Rd.</b>		d. STREET ADDRESS <b>123 Northwood Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>L.</b> Last <b>Frye</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1871</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>3</b> Days <b>4</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Uriah S. Wolfe</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jean Ross</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. La Rue S Jordan - 123 Northwood Ave. S. S.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>58</b> , to <b>November 6, 1958</b> , that I last saw the deceased alive on <b>Nov 2</b> , 19 <b>58</b> , and that death occurred at <b>6:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Aaron H. Traum</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>8237 Georgia Ave - Silver Spring Md Nov 6 58</b>	
PHYSICIAN'S NAME (Type) <b>Aaron H. Traum</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 9, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	22d. LOCATION (City, town, or county) <b>State</b> <b>Shipp, Armstrong Co.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey Inc.</b>		ADDRESS <b>8434 Georgia Ave.</b>	
24a. REC'D BY REGISTRAR <b>Raymond A. Ziaka</b>		DATE <b>NOV 10 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traum</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2 57

12678

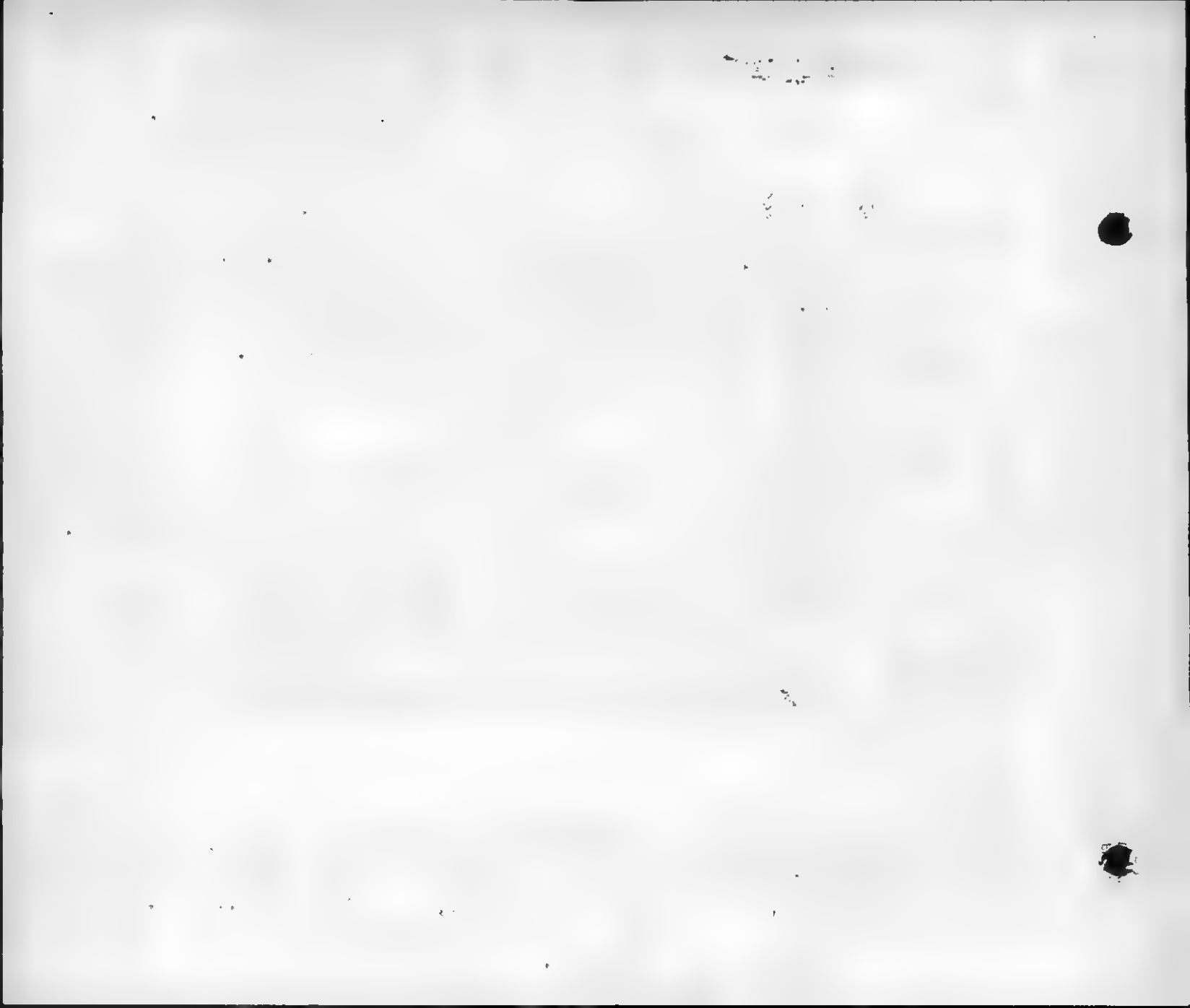
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13817

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5411 Goldsboro Rd</b>		d. STREET ADDRESS <b>5411 Goldsboro Rd,</b>	
3. NAME OF DECEASED (Type or print) First <b>Vander C.</b> Middle <b>Fulton</b> Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29,</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Unknown</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/ / 1906</b>
9. AGE (In years last birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>handy man</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Williamsburg, Co. S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Fulton</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Fleming.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Police Record</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>42-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Found dead on floor of his home.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
NAME (Type) <b>Frank J. Broschart</b>		DATE SIGNED <b>11/29/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipped</b>		22b. DATE OF REMOVAL <b>12/2/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Redmon Funeral Home.,</b>		22d. LOCATION (City, town, or county) (State) <b>King Street., S. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert L. Snowden</b>	





12679

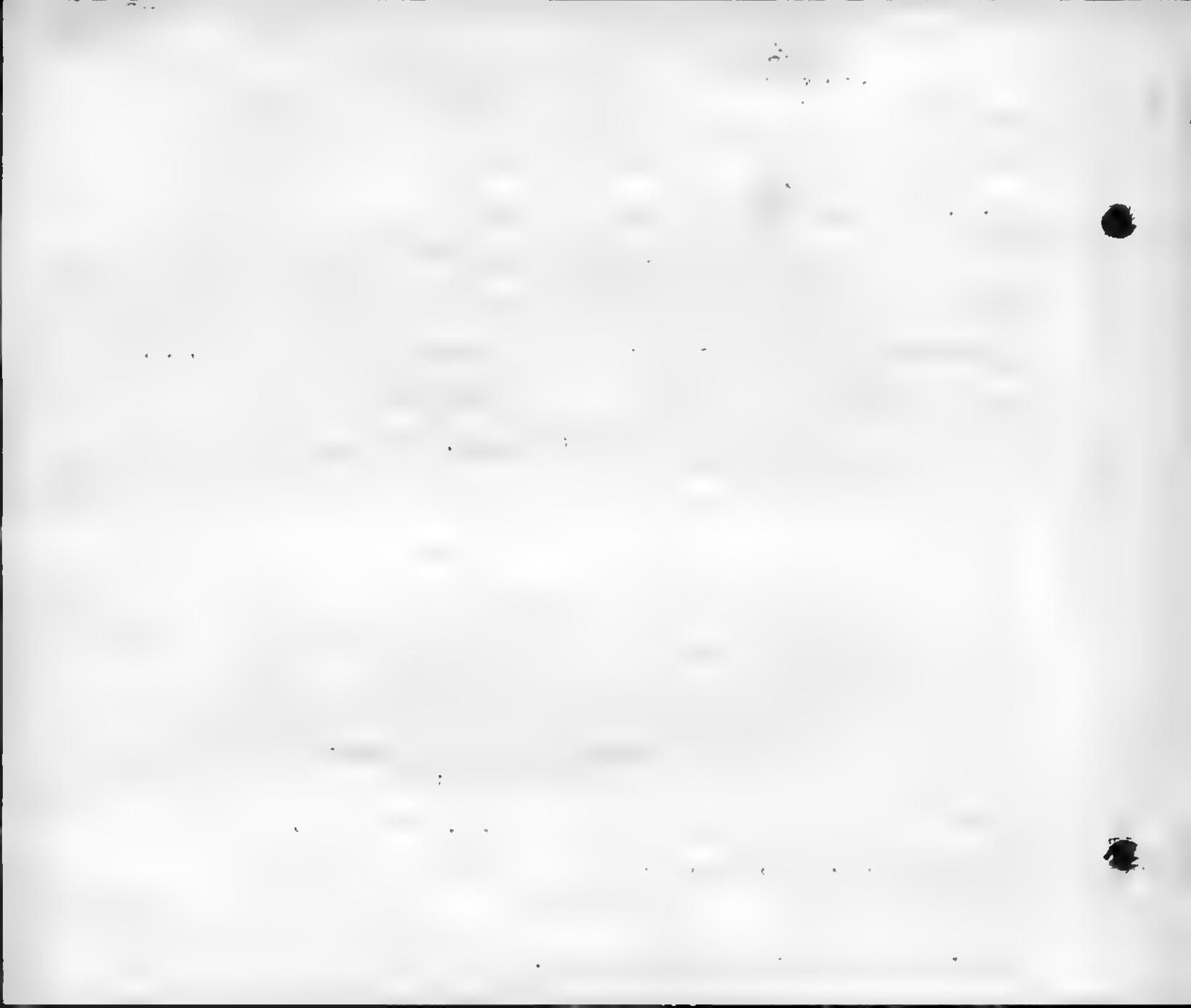
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jacoba</b> Middle <b>Francisca</b> Last <b>GERRITSEN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-22</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) <b>Holland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Johann AKELYEN</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia MAYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>550-42-4066</b>	
17. INFORMANT <b>(H) John M. Gerritsen, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ruptured cerebral hemorrhage</b> 230x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ruptured cerebral aneurysm</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 1, 1958</b> to <b>November 4, 1958</b> , that I last saw the deceased alive on <b>November 3, 1958</b> , and that death occurred at <b>5:10A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Matthew W. Wood MD</b> M.D. <b>U. S. Naval Hospital, NMC</b> <b>11-4-58</b>			
ACTUAL SIGNATURE <b>Matthew W. Wood MD</b>		PHYSICIAN'S NAME (Type) <b>M. W. WOOD, LCDR, MC, USN</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-6-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Newport News Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Riverside Funeral Home, Newport News, Va.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12680**  
**CERTIFICATE OF DEATH**

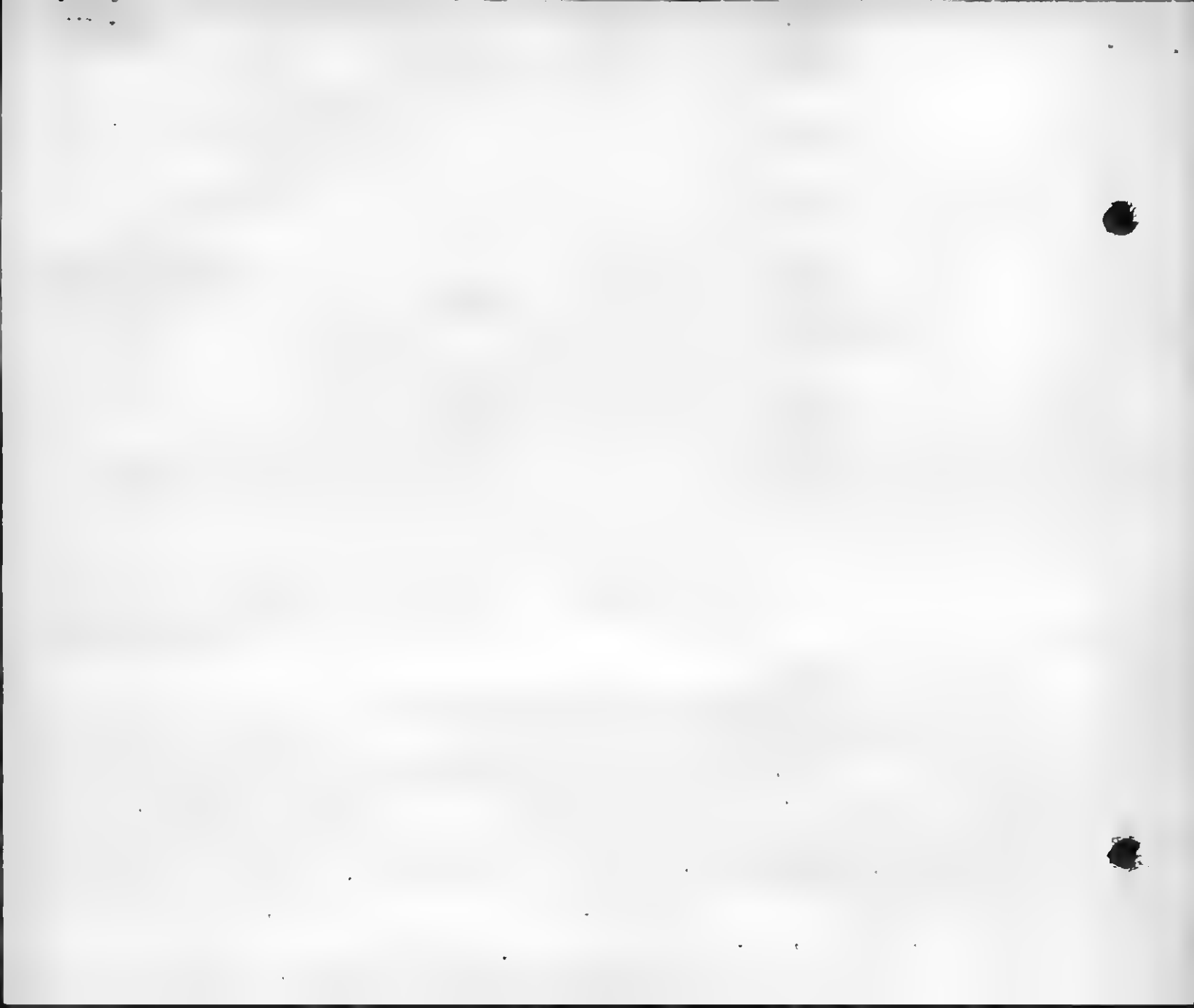
**12666**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				e. STREET ADDRESS <b>801 Northwest Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Wilma</b> Middle <b>Anna</b> Last <b>Goodyear</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/17/74</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>27</b> Hours <b>18</b> Min		11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>			
13. FATHER'S NAME <b>Daniel Goodyear</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Dunlop</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia Right lung</b>            (b) <b>Tracheobronchitis</b>            (c) <b>Generalized Arteriosclerosis</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH  <b>50 days</b>  <b>50 days</b>  <b>years</b></p> </div> </div> <p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/10, 1958</b> , to <b>11/12, 1958</b> , that I last saw the deceased alive on <b>11/12, 1958</b> , and that death occurred at <b>10:12 AM</b> , from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> <p>ACTUAL SIGNATURE <b>[Signature]</b></p> <p>PHYSICIAN'S NAME (Type) <b>G. H. Ligon, M. D.</b></p> </div> <div> <p>ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b></p> <p>DATE SIGNED <b>11/12/58</b></p> </div> </div>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BLANDFORD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PETERSBURG, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. FURNEY, INC.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>NOV 14 58</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12681

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

## CERTIFICATE OF DEATH

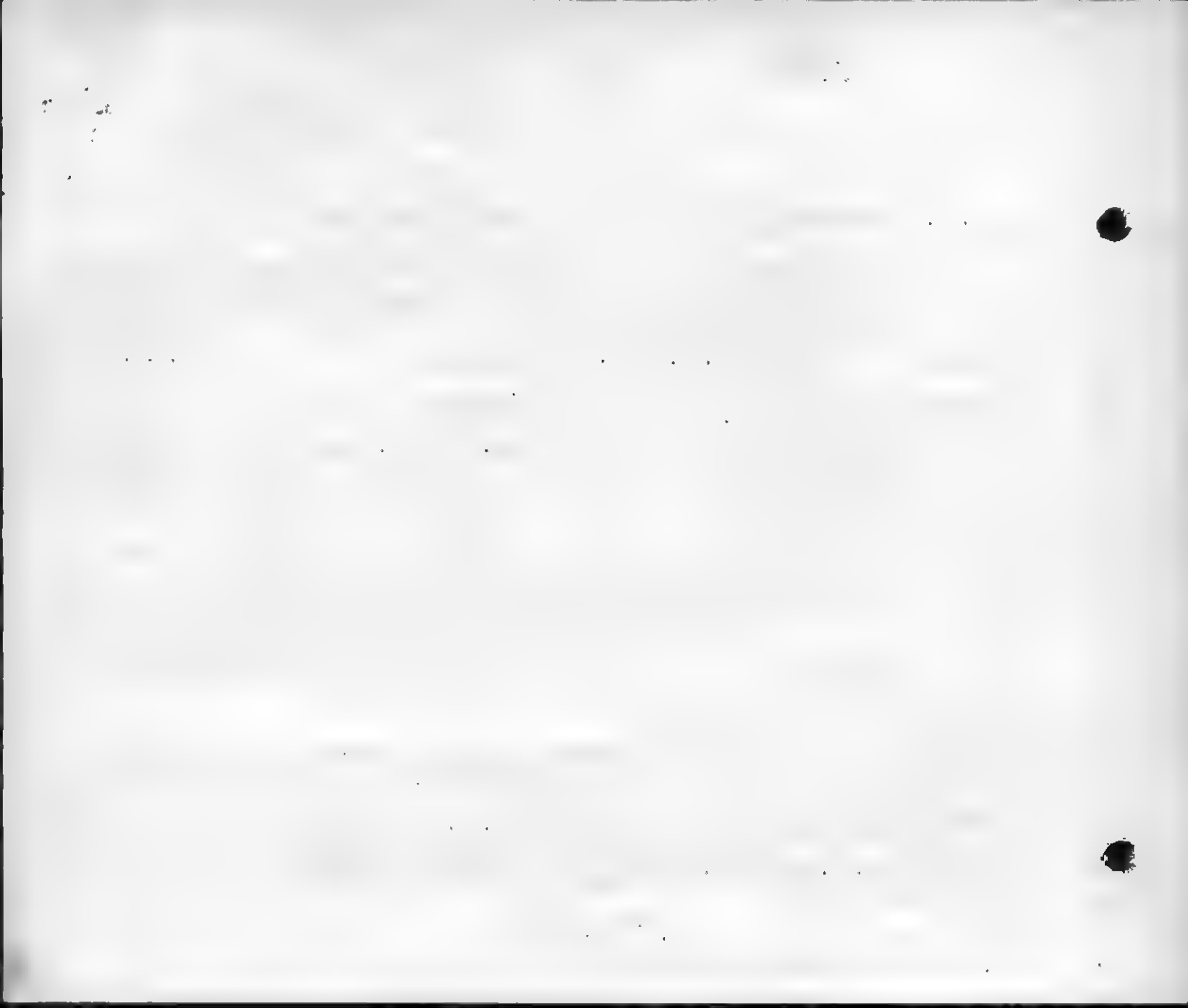
12667

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookmont</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>4310 Locust Lane</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas GORMAN</b>		4. DATE OF DEATH Month Day Year <b>November 14 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1876</b>
9. AGE (In years last birthday) <b>82 81 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael GORMAN</b>		14. MOTHER'S MAIDEN NAME <b>Margaret FITZGERALD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes SPAM - WWI</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>(W) Mrs. Clara B. Groman, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CONGESTIVE FAILURE</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>1 MONTH</b> <b>70 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RECURRENT PNEUMONIA</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 23, 19 58</b> to <b>November 14, 19 58</b> , that I last saw the deceased alive on <b>November 14, 19 58</b> , and that death occurred at <b>6:25P M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. S. Caldwell</b>		DATE SIGNED <b>11-15-58</b>	
PHYSICIAN'S NAME (Type) <b>F. S. CALDWELL, LT, MC, USN</b>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>	
ADDRESS <b>7551 Wisc. Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

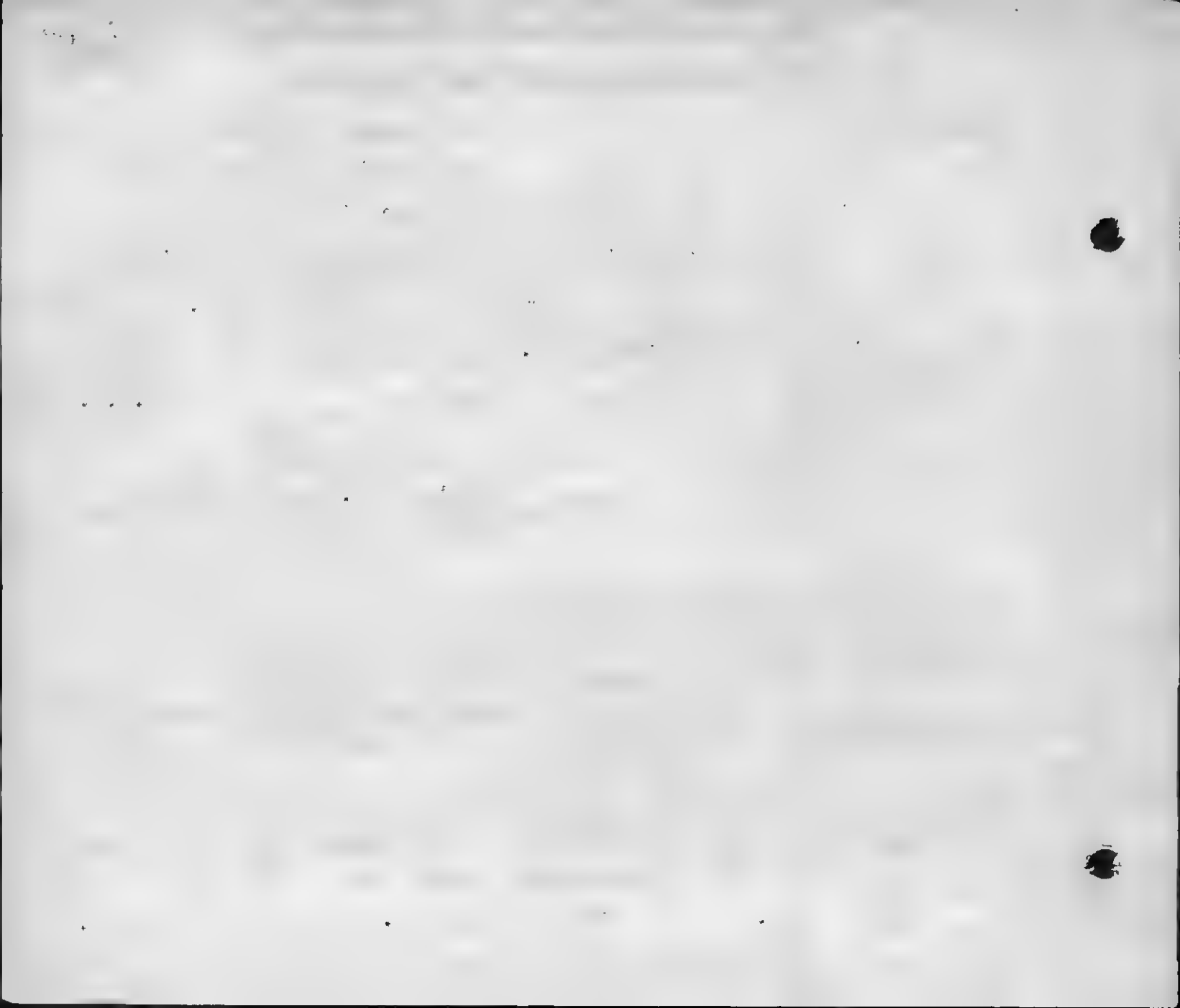
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12668

## 12622 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Montgomery</b>		STATE <b>Maryland</b> COUNTY <b>Montgomery</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
TOWN <b>Rockville</b>		LENGTH OF STAY (in this place) <b>5 Years</b>		TOWN <b>Rockville</b>		TOWN <b>Rockville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>813 North Washington</b>				STREET ADDRESS (If rural give location) <b>813 North Washington</b>			
3. NAME OF DECEASED (Type or Print) <b>Nellie Gray</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 5 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Oct. 8 1881</b>	
9. AGE last birthday <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Frances Evelyn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Lloyd W. Gray Same A. 2</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						IMMEDIATE CAUSE (A) <b>Coronary Arteriosclerosis</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerosis</b>	
STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Diabetes Mellitus</b>						10 yrs	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						15 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct 5 1958</b> to <b>Nov 5 1958</b> , that I last saw the deceased alive on <b>Nov 5 1958</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		M.D. <b>[Signature]</b>		ADDRESS (Street, city, town, state) <b>[Address]</b>		DATE SIGNED <b>[Date]</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Nov. 9</b>		NAME OF CEMETERY OR CREMATORY <b>Laytonsville, Meth.</b>		LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>Laytonsville, Md.</b>	
DATE <b>NOV 12 1958</b>							





12682

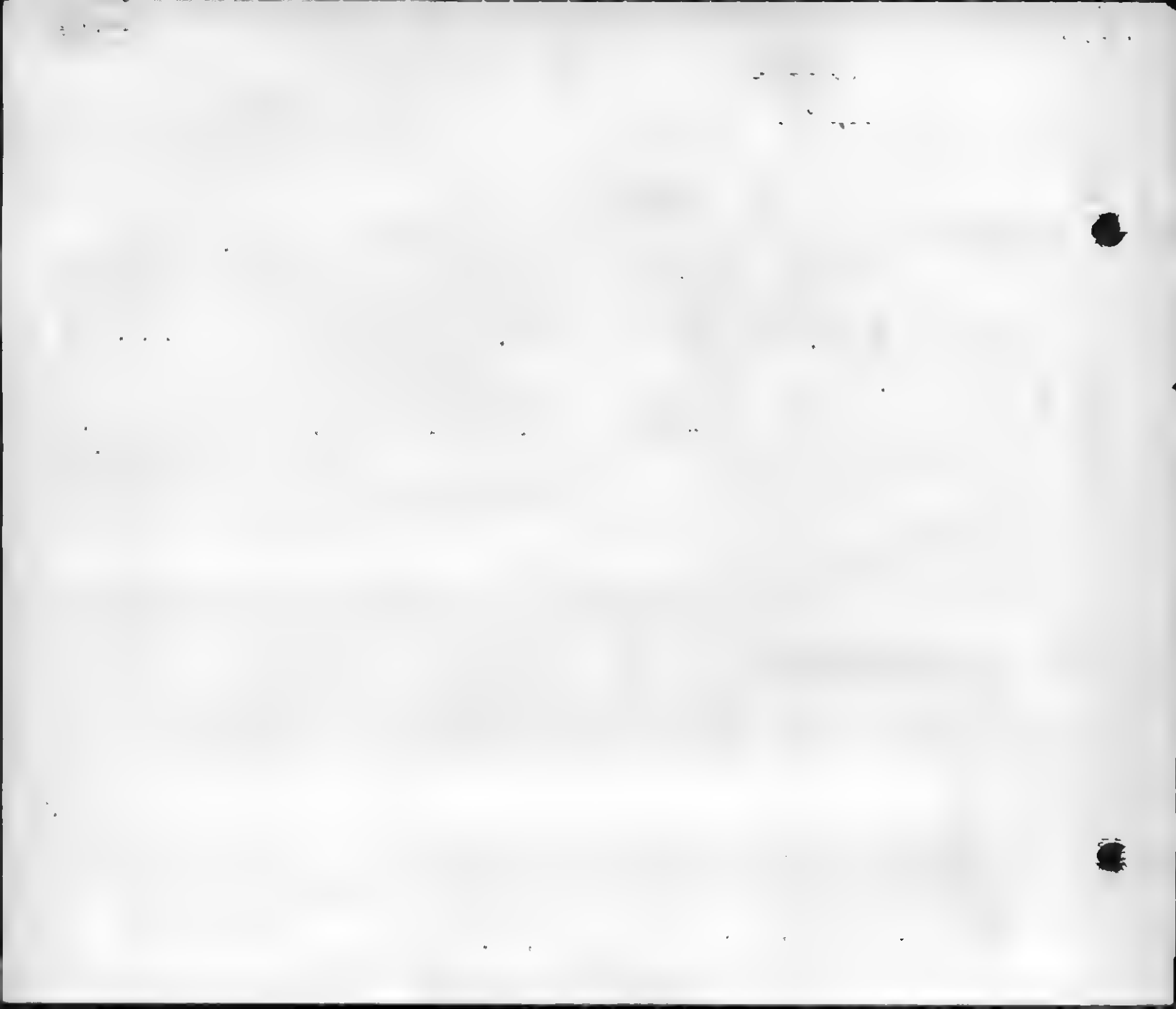
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAPLE LANE NURSING HOME</b>		d. STREET ADDRESS <b>8806 Manchester Road</b>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>DORSEY</b> Last <b>GRIFFITH</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>19</b> Year <b>1958</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/03</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Zone &amp; Field Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Motors Corp.</b>	
11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL D. GRIFFITH</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE GLOCK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>192-03-0539 H</b>	
17. INFORMANT Address <b>Mrs. Sara F. Griffith, 8806 Manchester Rd. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO <b>Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 years</b> (c) <b>years</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March, 1956</b> to <b>Nov 19, 1958</b> , that I last saw the deceased alive on <b>Nov 19, 1958</b> , and that death occurred at <b>6:55 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Curry</b> MD		ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md</b>	
PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>		DATE SIGNED <b>11/19/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/21/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GRANDVIEW CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>JOHNS TOWN, PENNSYLVANIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPERY, INC. Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	24a. REC'D BY REGISTRAR <b>NOV 20 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



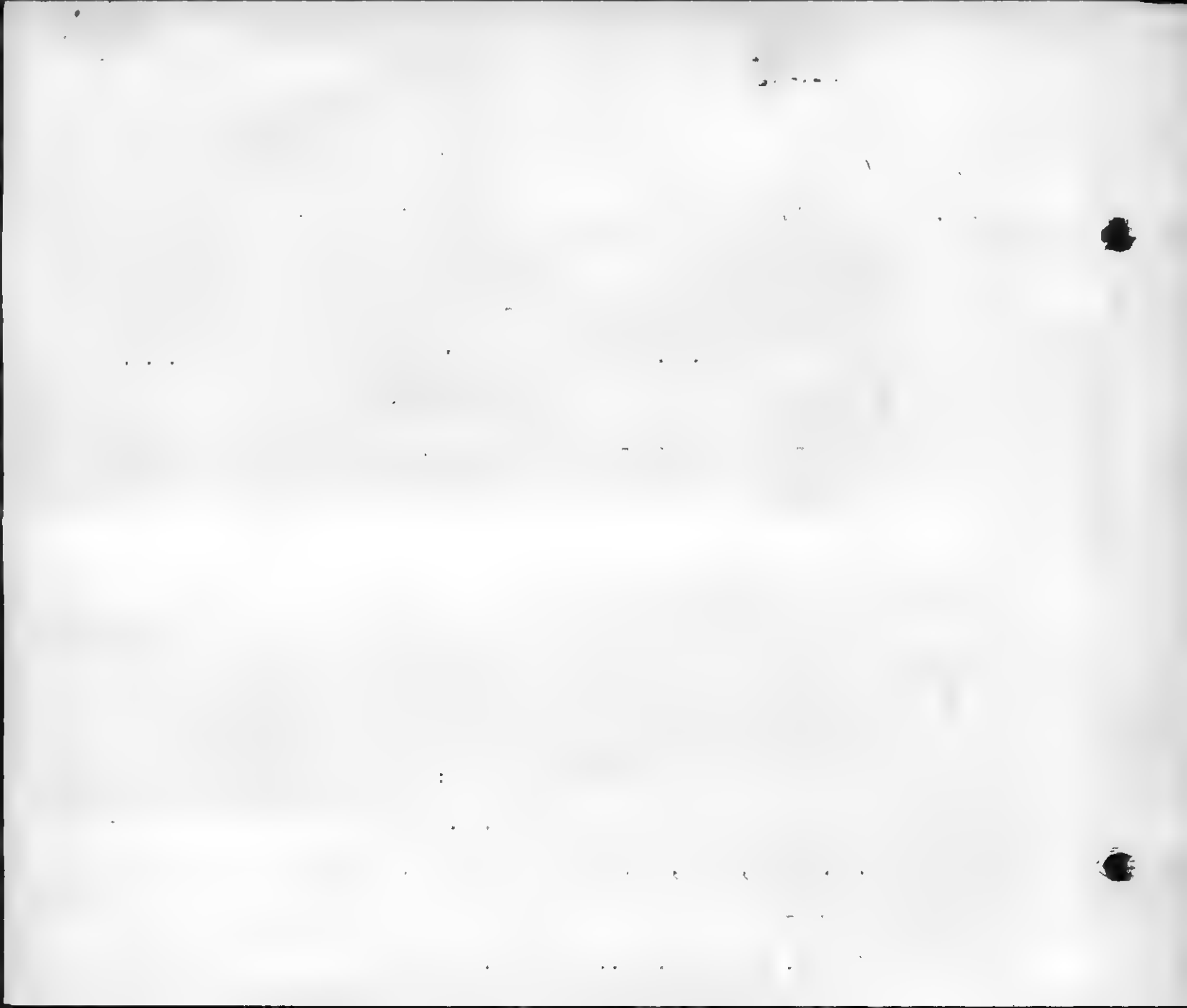
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12683**  
**CERTIFICATE OF DEATH**

**12670**

Reg. Dist. No. **215**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Montgomery</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>169 days</b>			c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>× Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>3 Pooks Hill Road - Apt 316</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"><span>First <b>Irving</b></span><span>Middle <b>GRODSTEIN</b></span><span>Last <b>GRODSTEIN</b></span></div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"><span>Month <b>November</b></span><span>Day <b>19</b></span><span>Year <b>19 58</b></span></div>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-7-15</b>	
9. AGE (In years last birthday) <b>43</b> yrs		IF UNDER 1 YEAR Months Days Hours M.n		IF UNDER 24 HRS Months Days Hours M.n			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel GRODSTEIN</b>				14. MOTHER'S MAIDEN NAME <b>Mary CANTERMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WWII - KOREA</b>				16. SOCIAL SECURITY NO <b>245-60-5473</b>		17. INFORMANT <b>Official Navy Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Carcinoma, colon, with generalized metastases</b>  <b>153.8</b>  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____  DUE TO (c) _____ </div>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3</b> 19 <b>58</b> , to <b>November 19</b> 19 <b>58</b> , that I last saw the deceased alive on <b>November 19</b> 19 <b>58</b> , and that death occurred at <b>1:30P</b> M, from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> ACERTIFY SIGNATURE <b>Larry J. Hines</b>  PHYSICIAN'S NAME (Type) <b>L. J. HINES, LCDR, MC, USN</b> </div> <div> ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>  DATE SIGNED <b>11-19-58</b> </div> </div>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-21-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Adams Funeral Home, 4748 Wisc. Ave., NW, Wash., DC</b>				24a. REC'D BY REGISTRAR <b>NOV 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57



12684

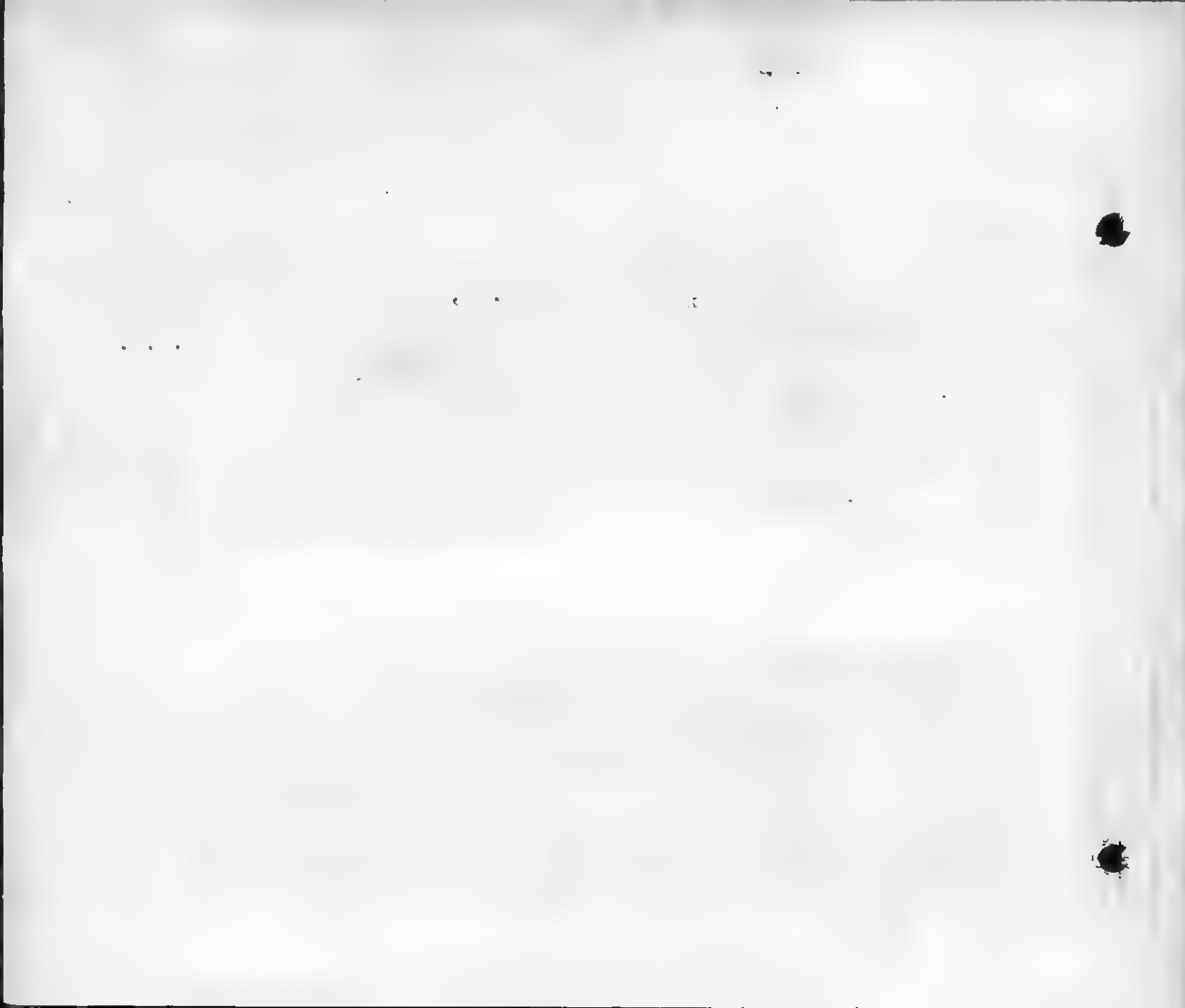
CERTIFICATE OF DEATH

Reg. Dist. No.

12671

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>1107 Rockville Pike</b>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Herbert</b> Last <b>Gross</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Herbert</b>		14. MOTHER'S MAIDEN NAME <b>Anna Yoski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>ANNA M. Williams - Daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized cerebral arteriosclerosis</b> (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b> <b>2 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1957</b> to <b>Nov. 22, 1958</b> , that I last saw the deceased alive on <b>Nov. 1-2, 1958</b> , and that death occurred at <b>9:42 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>H. Bonetto / H. M. D.</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PARK</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harley Miller 2334 Jefferson St.</b>		24a. REC'D BY REGISTRAR DATE <b>11/25/58</b>	24b. REGISTRAR'S SIGNATURE <b>John L. Williams</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12685

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>		d. STREET ADDRESS <b>13606 Layhill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith Bruce Haas</b>		4. DATE OF DEATH Month Day Year <b>November 6 19 58</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/14/84 1883</b>		9. AGE (In years last birthday) <b>75 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>David S. Morse</b>		14. MOTHER'S MAIDEN NAME <b>Edith M. Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Olney, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized advanced arteriosclerosis</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Silver Spring</b>		(County) <b>Prince George's</b>		(State) <b>Md.</b>		21. I certify that I attended the deceased from <b>June 1958</b> to <b>Nov 1958</b> , that I last saw the deceased alive on <b>Nov 5 1958</b> , and that death occurred at <b>5:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>A. D. Bonifant</b>		M. D. <b>A. D. Bonifant, M. D.</b>		PHYSICIAN'S NAME (Type) <b>Sandy Spring, Md.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) <b>PRINCE GEO. COUNTY, MARYLAND</b>		22e. (State) <b>MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>		24c. (City or town) <b>Silver Spring</b>		(County) <b>Prince George's</b>		(State) <b>Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4: may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4-1-2-



12686

## CERTIFICATE OF DEATH

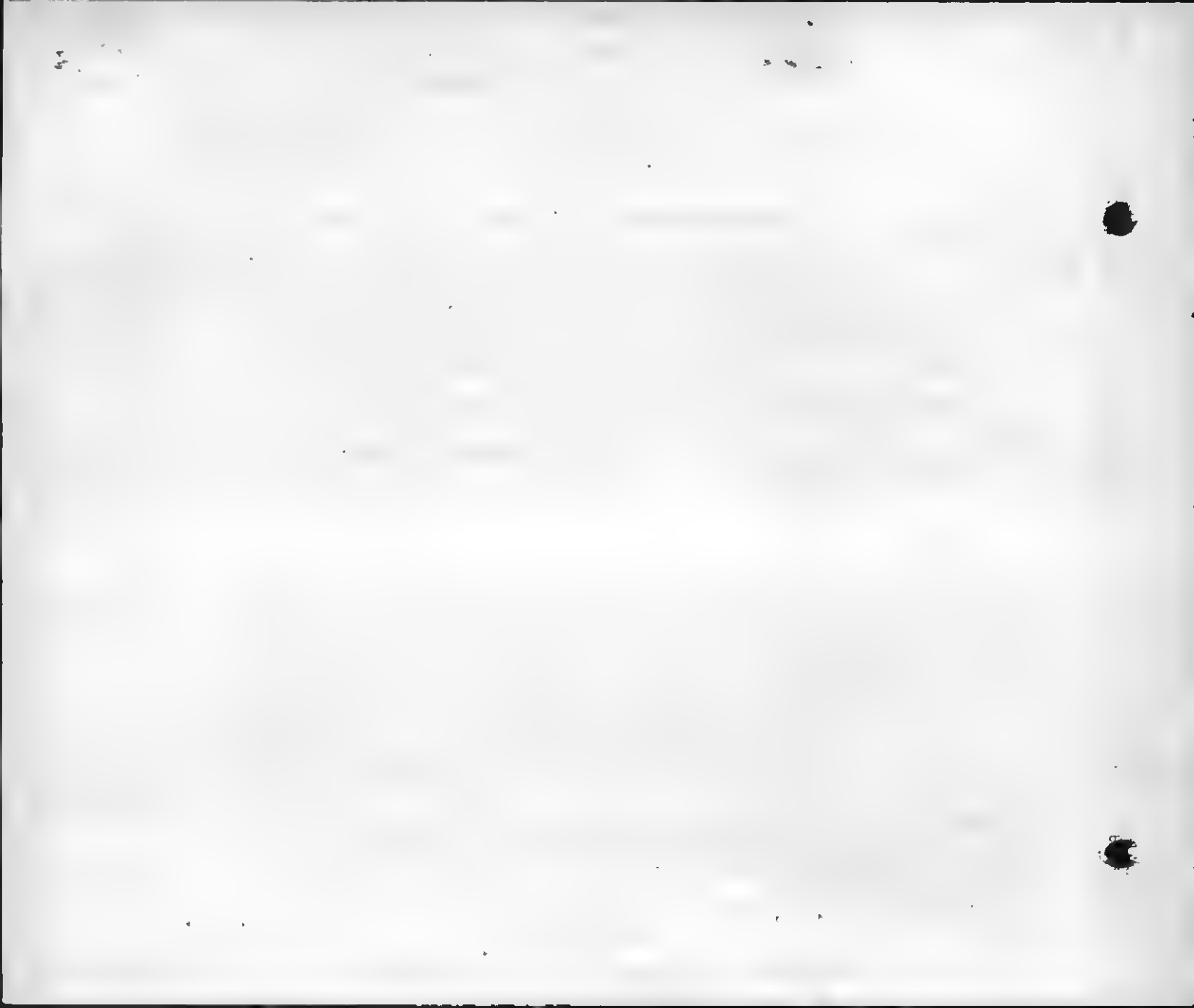
12673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 28 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital Inc.</u>		d. STREET ADDRESS <u>Box 14</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Harrison</u>		4. DATE OF DEATH Month <u>11.28.</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11.28.58</u>
9. AGE (In years last birthday) yrs <u>1</u> Months <u>28</u> Days <u>1</u> Hours <u>28</u> Min <u>28</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James H. Harrison</u>	
14. MOTHER'S MAIDEN NAME <u>Edna R. Riggleman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Hospital Records.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral stenosis</u> <u>762.5</u> DUE TO <u>Pre-maturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pre-maturity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>11</u> p. m. <u>28</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>58</u> , to <u>11/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>58</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> DATE SIGNED <u>11/30/58</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr, M. D.</u>		<u>Damascus, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>True Gospel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Liebon, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Woloszewski</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Risher</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12687

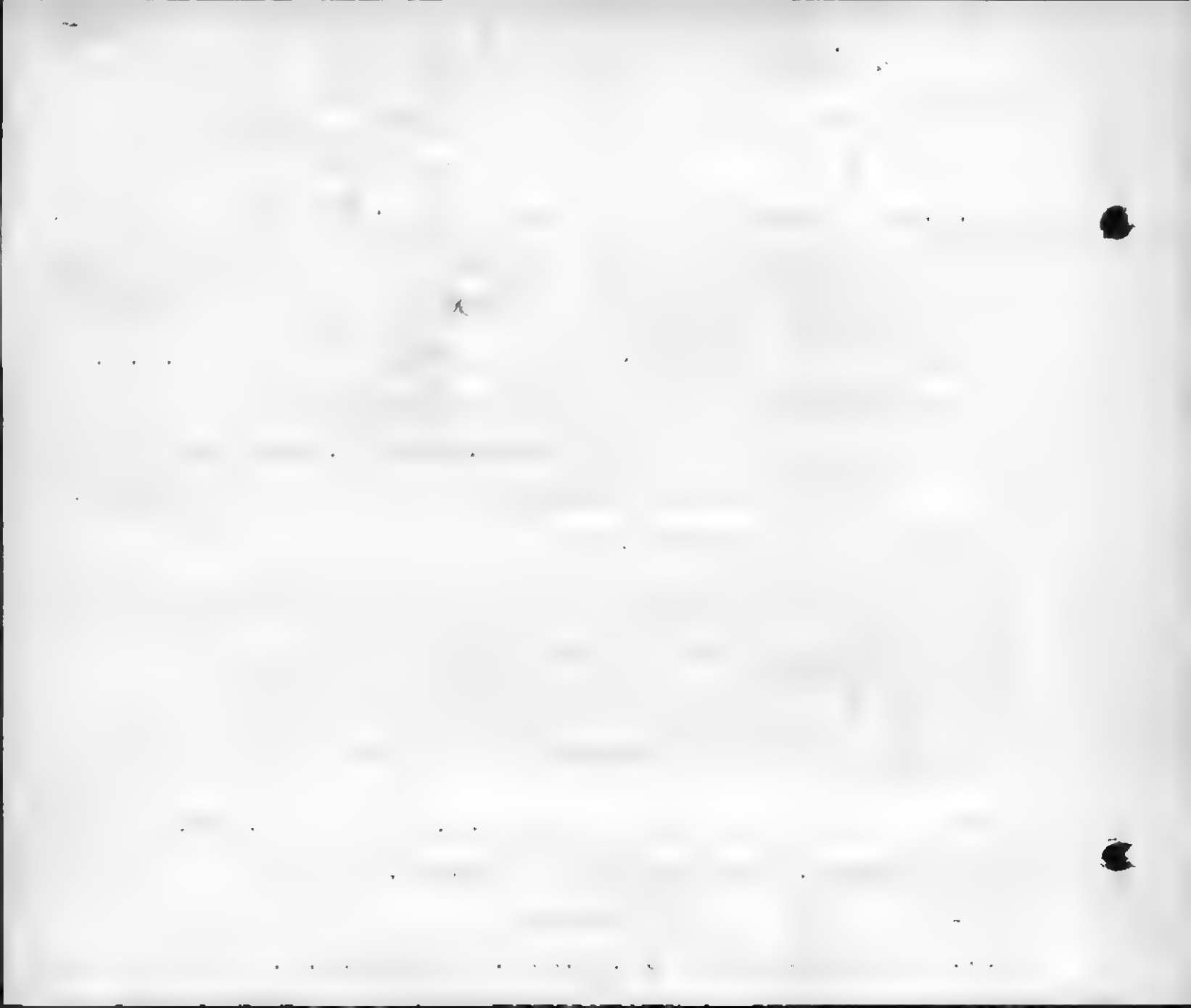
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>30 days</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Falls Church</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> d. STREET ADDRESS <b>614 No. Oak Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sadie Mae HARVEY</b> First Middle Last		4. DATE OF DEATH <b>November 3 19 58</b> Month Day Year	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-18-90</b> <b>10-18-90</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Womens Wear</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael MC CARTHY</b>		14. MOTHER'S MAIDEN NAME <b>Nora MC GOUGH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>549 16 6781A</b>	
17. INFORMANT <b>(D) Mrs. Patricia M. Hansen Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>110X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma, Breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 4, 19 58</b> , to <b>November 3, 19 58</b> , that I last saw the deceased alive on <b>November 3, 19 58</b> , and that death occurred at <b>9:30AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NMHC, 11-3-58</b>			
ACTUAL SIGNATURE <b>Robert C. Thomas</b> M.D.			
PHYSICIAN'S NAME (Type) <b>ROBERT C. THOMAS LT MC USN Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-7-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Parsons Kansas</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. J. SAFFELL</b> ADDRESS <b>475 H. St., N. W., Washington, D. C.</b>		24a. REC'D BY REGISTRAR <b>11-15-58</b>	24b. REGISTRAR'S SIGNATURE <b>C. Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**12675**

**FOR STATE  
HEALTH DEPT.**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>D.O.I.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Germantown (rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				f. STREET ADDRESS <u>1111 D. H. C. Box 30</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lice</u> First <u>Christine</u> Middle <u>Hawkins</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>r</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1937</u>		9. AGE (In years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEATH PLACE (State or foreign country)</u>		11. BIRTHPLACE (State or foreign country) <u>Germantown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hawkins</u> <u>-same-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Gladys Hawkins (sister)</u> Address <u>Same as above.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral confluent broncho-pneumonia</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <u>Nov. 10/ 1958</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, or to burial, cremation, or removal, and in any event within 72 hours after death.



12689

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>69 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Madisonville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madisonville</u> d. STREET ADDRESS <u>204 South Franklin Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruby Cordelia Hawkins</u>			4. DATE OF DEATH Month Day Year <u>November 23, 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1898</u>		9. AGE (In years last birthday) <u>60 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>George West Cooke</u>		
14. MOTHER'S MAIDEN NAME <u>Cordelia Sisk</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>404-12-7490</u>			17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the thyroid gland</u> <u>194x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with laryngotracheal obstruction</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>					
19. WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>September 15, 1958, to November 23, 1958</u>		20g. (County) <u>November 23, 1958</u>		20h. (State) <u>2:40 P.M.</u>	
21. I certify that I attended the deceased from <u>September 15, 1958</u> , to <u>November 23, 1958</u> , that I last saw the deceased alive on <u>November 23, 1958</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/24/58</u> ACTUAL SIGNATURE <u>James A. Rose, M.D.</u> PHYSICIAN'S NAME (Type) <u>James A. Rose, M. D.</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Madisonville, Kentucky</u>	
22d. LOCATION (City, town, or county) <u>Madisonville, Kentucky</u>		22e. (State) <u>Madisonville, Kentucky</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Tread</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57





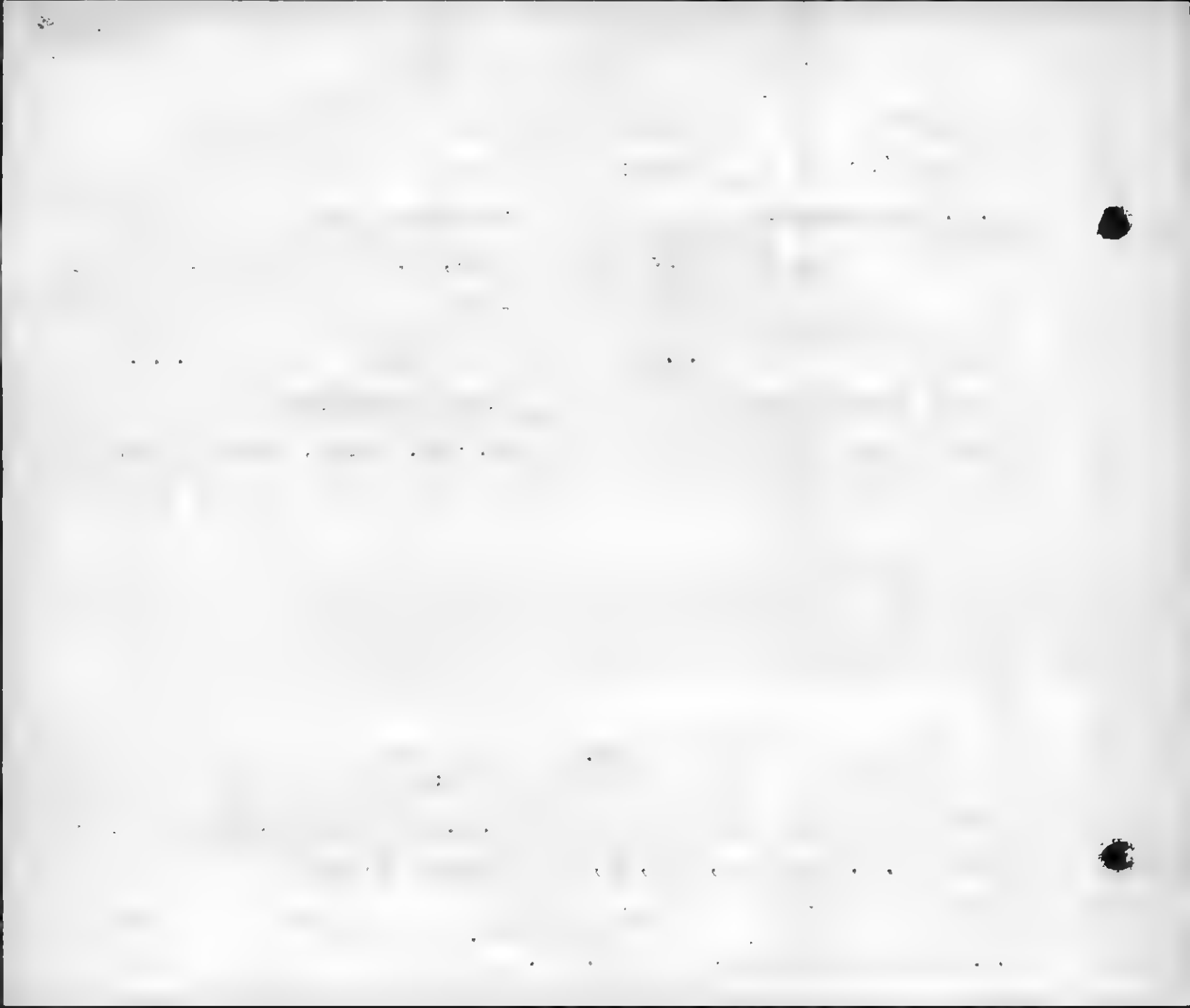
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12690**  
**CERTIFICATE OF DEATH**

**12677**

Reg. Dist. No. **215**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>41 days</b>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>8613 Melwood Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Everett HAZLETT, JR.</b>				4. DATE OF DEATH Month Day Year <b>November 2 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-29-92</b>	
9. AGE (In years last birthday) <b>66 yrs</b>		IF UNDER 1 YEAR Months Days Hours M n		IF UNDER 24 HRS Months Days Hours M n			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Edward Everett HAZLETT</b>				14. MOTHER'S MAIDEN NAME <b>Alice Elizabeth MOTT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WWI - WWII</b>				16. SOCIAL SECURITY NO <b>(W) Mrs. Eliz. Hazlett, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Lung</b> <b>16 J x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <b>Sept. 22, 1958</b> to <b>November 2, 1958</b> , that I last saw the deceased alive on <b>November 1, 1958</b> , and that death occurred at <b>7:35A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. E. Richardson</b> M.D.				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b>			
DATE SIGNED <b>11-3-58</b>							
PHYSICIAN'S NAME (Type) <b>H. E. RICHARDSON, CAPT, MC, USN Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> <b>R.A. Pumphrey Funeral Home, 7557 Wisc. Ave.,</b>				24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12678

12691

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montg</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN lb <b>35 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		g. STREET ADDRESS <b>1-Montgomery Ave</b>	
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Millard</b> First <b>Edward</b> Middle <b>Heim</b> Last		4. DATE OF DEATH Month <b>Nov</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 24-1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR Months <b>6</b> Days <b>24</b> Hours <b>19</b> Min	11. IF UNDER 24 HRS Months <b>6</b> Days <b>24</b> Hours <b>19</b> Min	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		13. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
14. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		15. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
16. FATHER'S NAME <b>Edward L. Heim</b>		17. MOTHER'S MAIDEN NAME <b>Malinda S. Kemp</b>	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		19. SOCIAL SECURITY NO	
20. INFORMATION <b>Bessie L. Heim. Rockville. Md.</b>		Address	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Accident</b> DUE TO (c)			
22. INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>4 1/2 days</b>			
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
26a. TIME OF INJURY Hour <b>a. m.</b> Month <b>11</b> Day <b>22</b> Year <b>1958</b>	26b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	26c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	26d. (City or town) (County) (State)
27. I certify that I attended the deceased from <b>11-22-1958</b> to <b>11-26-1958</b> , that I last saw the deceased alive on <b>11-26-1958</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.			
28. ACTUAL SIGNATURE <b>F. J. Bloesch</b> M.D.		29. ADDRESS (Street, city or town, state) DATE SIGNED <b>8 Russell Ave Gaithersburg Md 11-27-58</b>	
30. PHYSICIAN'S NAME (Type) <b>F. J. Bloesch</b>		31. ADDRESS <b>Gaithersburg Md.</b>	
32a. BURIAL, CREMATION, REMOVAL (Indicate)	32b. DATE THEREOF <b>11-28-58</b>	32c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	32d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md.</b>
33. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. ...</b>		34a. REC'D BY REGISTRAR <b>DEC 1 1958</b>	34b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12692

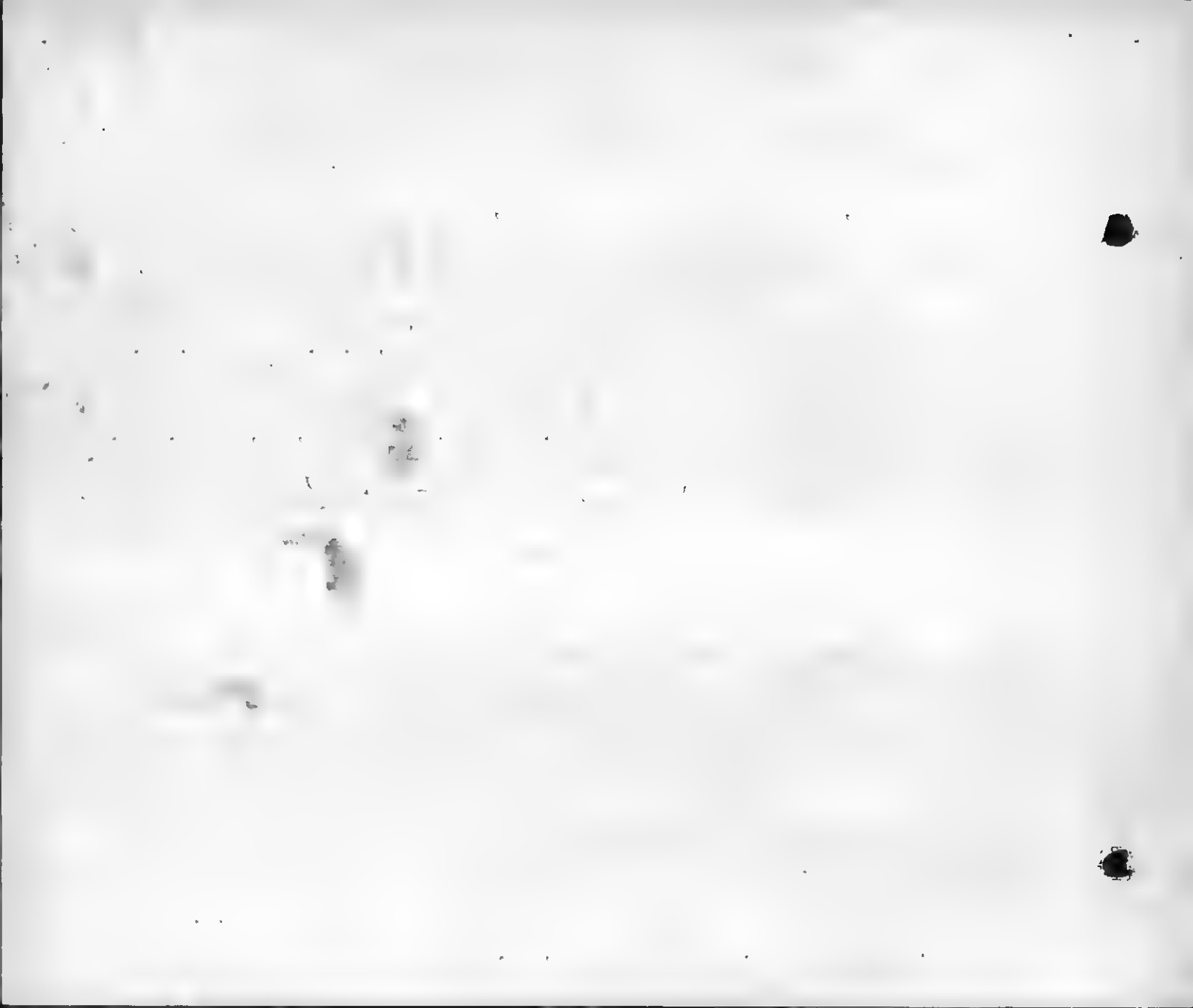
## CERTIFICATE OF DEATH

12679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,213 GEORGIA AVENUE</b>		e. STREET ADDRESS <b>10,213 GEORGIA AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM CHARLES HEITMULLER</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 9 19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/69</b>
9. AGE (In years last birthday) <b>89</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Produce</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES HEITMULLER</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE HEITMULLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Mrs. Minna E. Heitmuller, 10,213 Ga. Ave. Silver Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Kidney Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Peripheral Arteriosclerosis &amp; gangrene of 2 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>6/1/52</b> , 19___, to <b>11/9/58</b> , 19___, that I last saw the deceased alive on <b>11/9/58</b> , 19___, and that death occurred at <b>12:50 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md</b> DATE SIGNED <b>11/9/58</b>	
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/11/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 17 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiana</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12693

## CERTIFICATE OF DEATH

12680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Higgins</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10 1905</u>	9. AGE (In years last birthday) <u>52</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Gorman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dr. G. Bowditch Hunter</u> Address <u>Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident - 331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>Nov</u> Day <u>17</u> Year <u>1957</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>Rockville</u>		(County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Oct 2, 1957</u> to <u>Nov 17, 1957</u> , that I last saw the deceased alive on <u>Nov 17, 1957</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Bowditch Hunter, M.D.</u>				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd.; Rockville</u> DATE SIGNED <u>11/17/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov 21 1958</u>		24b. REGISTRAR'S SIGNATURE <u>G. G. Hunter</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

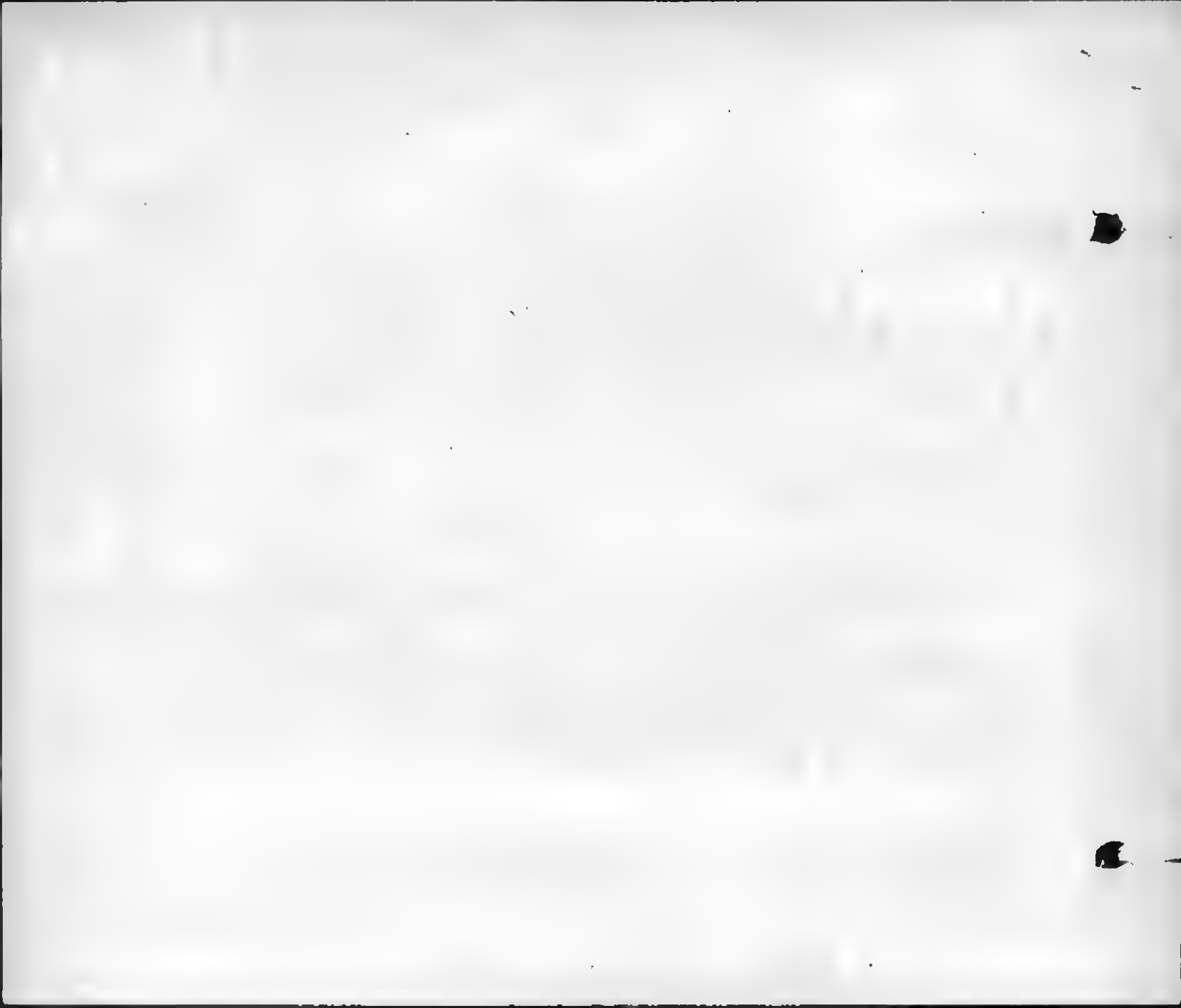
12681

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>md</u> b COUNTY <u>montg</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c LENGTH OF STAY IN lb <u>life</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10500 McArthur Blvd. (west 14 St)</u>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
f STREET ADDRESS <u>10500 McArthur Blvd. (west 14 St)</u>		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence Leonard Hill</u>		4. DATE OF DEATH <u>Nov 24 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-7-86</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> M'n. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levy D. Hill</u>		14. MOTHER'S MAIDEN NAME <u>Julie Marston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Yes-Unknown</u>	
17. INFORMANT <u>Rose Hill (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Abdominal hemorrhage</u> DUE TO (b) <u>shot gun wound in upper abdomen</u> DUE TO (c) <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self-inflicted shot gun wound</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>Nov 24 1958</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. (City or town) <u>Cabin John</u>		(County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church</u>		22d. LOCATION (City, town, or county) <u>Potomac, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Nov 28 58</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. &amp; H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**12682**

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>(rural) R-2</b>				d. STREET ADDRESS <b>(rural) R-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ella Blanche Hill</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> , Year <b>1958</b>		9. AGE (In years last birthday) <b>66</b> yrs.	
5. SEX <b>female</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/1892</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ma.</b>		11. BIRTHPLACE (State or foreign country) <b>Ma.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Dove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>Previous C.V.A. about 7 mo. ago.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<b>11/30/58</b>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION READY (if any) <b>Burial</b>		22b. DATE THEREOF <b>12/3/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park,</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 5 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Robert L. Snowden</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12696

## CERTIFICATE OF DEATH

12683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY: <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7108 Oak Forest Lane</u>				d. STREET ADDRESS <u>7108 Oak Forest Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Della Hoffman</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/1876</u>		9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <u>2</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Melvin Dreisbach</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Mr. Clifford Battles</u>		Address <u>7108 Oak Forest Lane Bethesda, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: 4. <input checked="" type="checkbox"/> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral Arteriosclerosis &amp;</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm thoracic aorta</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/2</u> 19 <u>58</u> , to <u>11/20</u> 19 <u>58</u> , that I last saw the deceased alive on <u>11/19</u> 19 <u>58</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>W. Luther Hall</u> M.D. <u>11500 Ave</u> <u>11/20/58</u>							
ACTUAL SIGNATURE <u>W. Luther Hall</u> M.D. <u>11500 Ave</u> <u>11/20/58</u>							
PHYSICIAN'S NAME (Type) <u>W. Luther Hall</u> <u>Wash. 6, D.C.</u>							
22a. BURIAL CREMATION REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barberton, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



12697

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>0-00,</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>0-00</u> b. COUNTY <u>0-00</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Rural. 0-00</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Faithersburg.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Linwood</u> Middle <u>Howard</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>15th</u> Year <u>1958</u>			
5. SEX <u>1e</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4-1874</u>	9. AGE (In years last birthday) <u>84 yrs.</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Montg Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>W. L. Howard</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Name <u>Dr. J. C. Howell</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE ARTERIOSCLEROSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 0.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/29</u> , 195 <u>8</u> , to <u>11/15</u> , 195 <u>8</u> , that I last saw the deceased alive on <u>11/15</u> , 195 <u>8</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10211 Georgia Ave Silver Spring Maryland</u> DATE SIGNED <u>11/16/58</u>							
ACTUAL SIGNATURE <u>Henry W. Stout MD</u>		PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-12-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Airy</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Faithersburg Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





12698

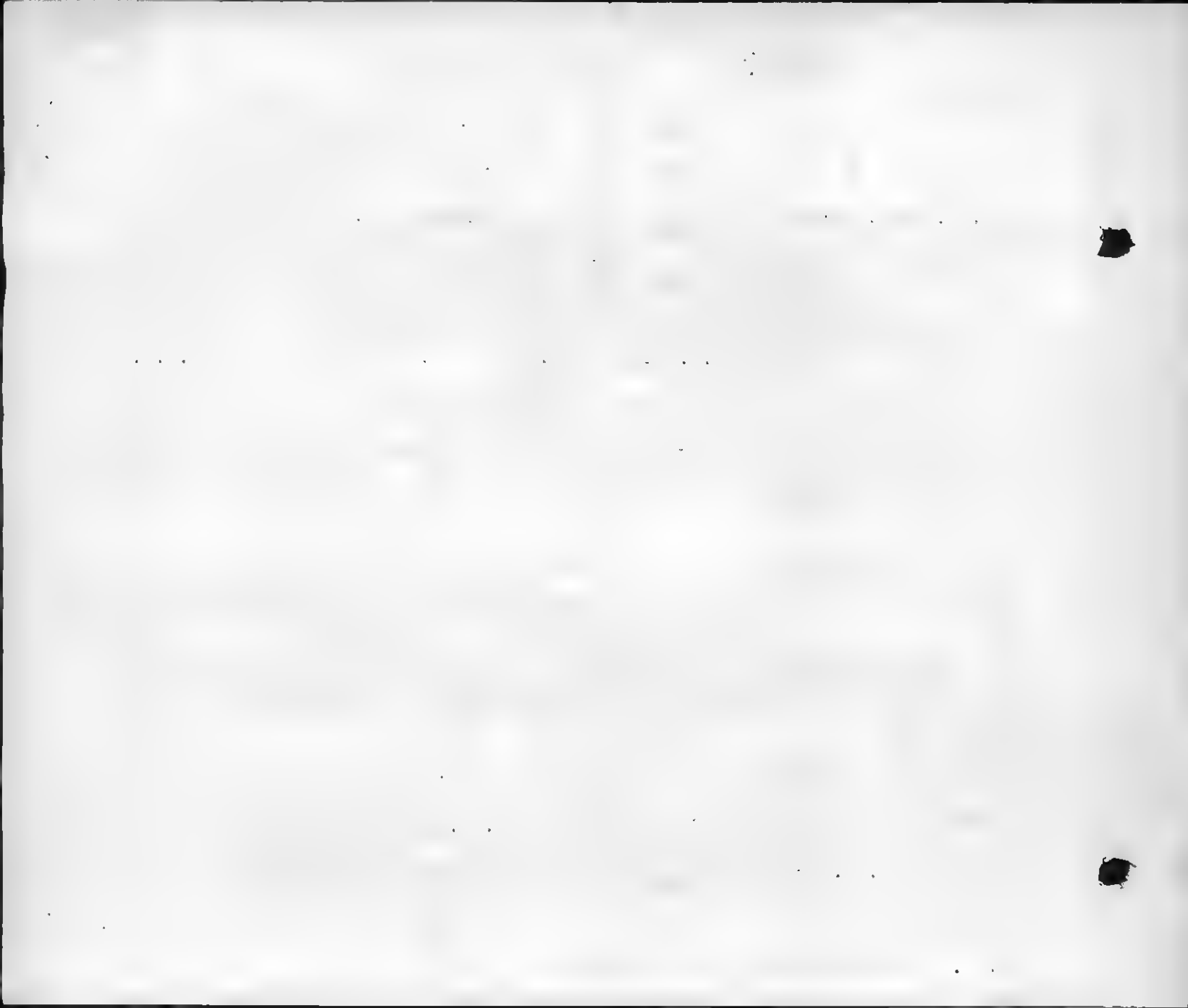
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>46 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Marshall</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cameron</b> d. STREET ADDRESS <b>19 Fleming Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter Elbert HOWARD</b>				4. DATE OF DEATH Month Day Year <b>November 30 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-6-99</b>	
9. AGE (In years last birthday) <b>59 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Diplomatic Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. State Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George HOWARD</b>		14. MOTHER'S MAIDEN NAME <b>Sarah DAYTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>235-24-8436</b>		17. INFORMANT Address <b>(W) Mrs. Mary Opal Howard, same as #2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma in the L.</b> <b>1-2-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1-2-1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 15 19 58</b> to <b>November 30 19 58</b> , that I last saw the deceased alive on <b>November 30 19 58</b> , and that death occurred at <b>6:30P M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NMMC 12-1-58</b>							
ACTUAL SIGNATURE <b>C. A. Muth</b> M.D.				PHYSICIAN'S NAME (Type) <b>R. G. MUTH, LT. MC, USN</b> Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Halcyon Hills Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Wheeling W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b> ADDRESS <b>Funeral Home, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12699

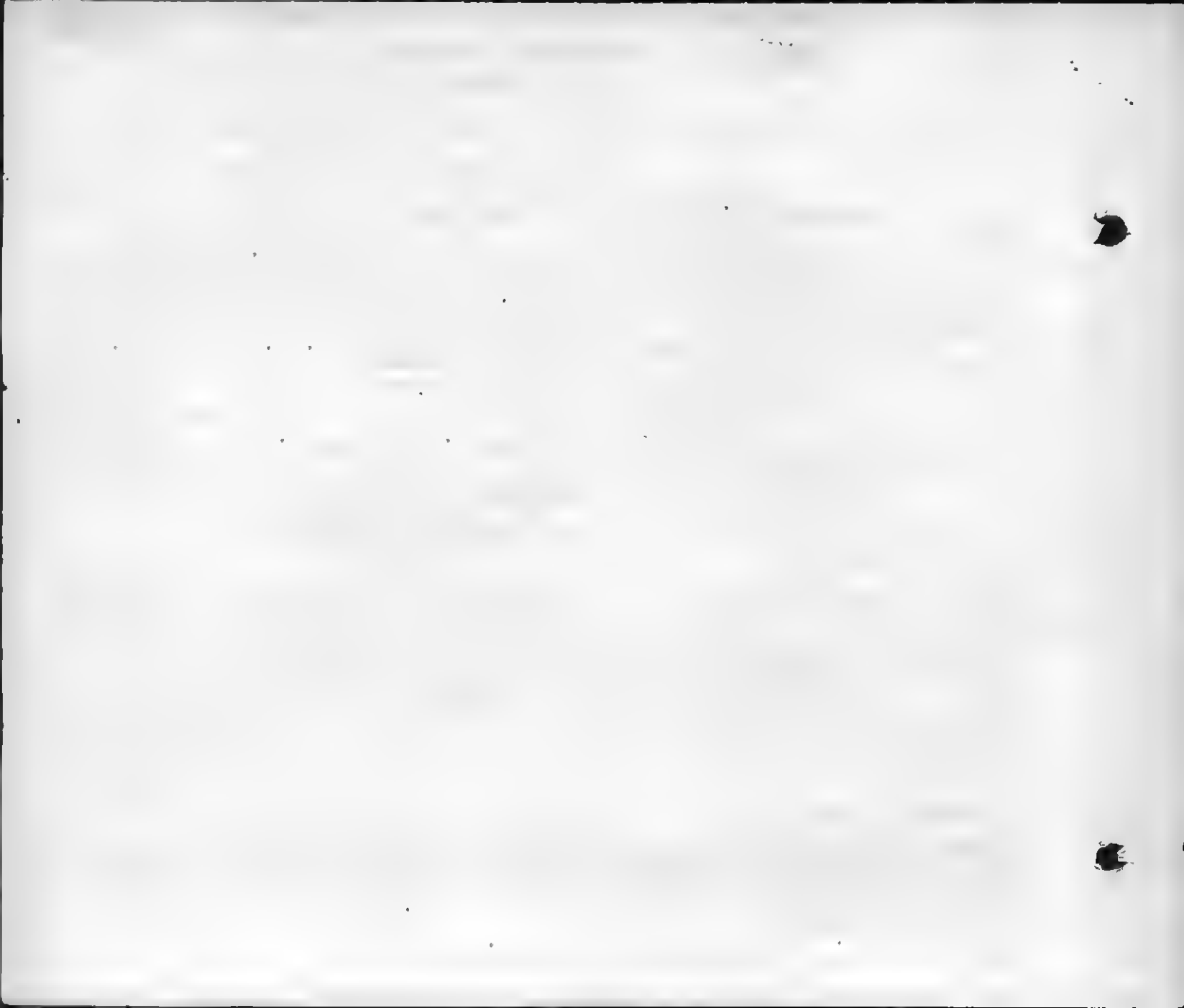
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6109 Greentree Road, Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6109 Greentree Rd.,</b>		d. STREET ADDRESS <b>6109 Greentree Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>LE ROY</b> Last <b>HUGHES</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Charles Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Goggin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>577-03-0261</b>	
17. INFORMANT <b>Son -</b>		Address <b>Same as Item 1.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIO PULMONARY FAILURE</b> (c) <b>DISSEMINATED CARCINOMATOSIS</b> <b>CARCINOMA OF THE STOMACH.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>NONE</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCTOBER 9, 1958</b> to <b>NOVEMBER 8, 1958</b> , that I last saw the deceased alive on <b>NOVEMBER 7, 1958</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11/8/58</b> DATE SIGNED <b>Edward S. Witowski, Jr. M.D. SUITE 400, 8218 WISCONSIN AVE.</b>			
ACTUAL SIGNATURE <b>Edward S. Witowski, Jr. M.D.</b>		PHYSICIAN'S NAME (Type) <b>EDWARD S. WITOWSKI, JR. M.D. BETHESDA 19, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-12-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>	22d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>John L. Kead</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



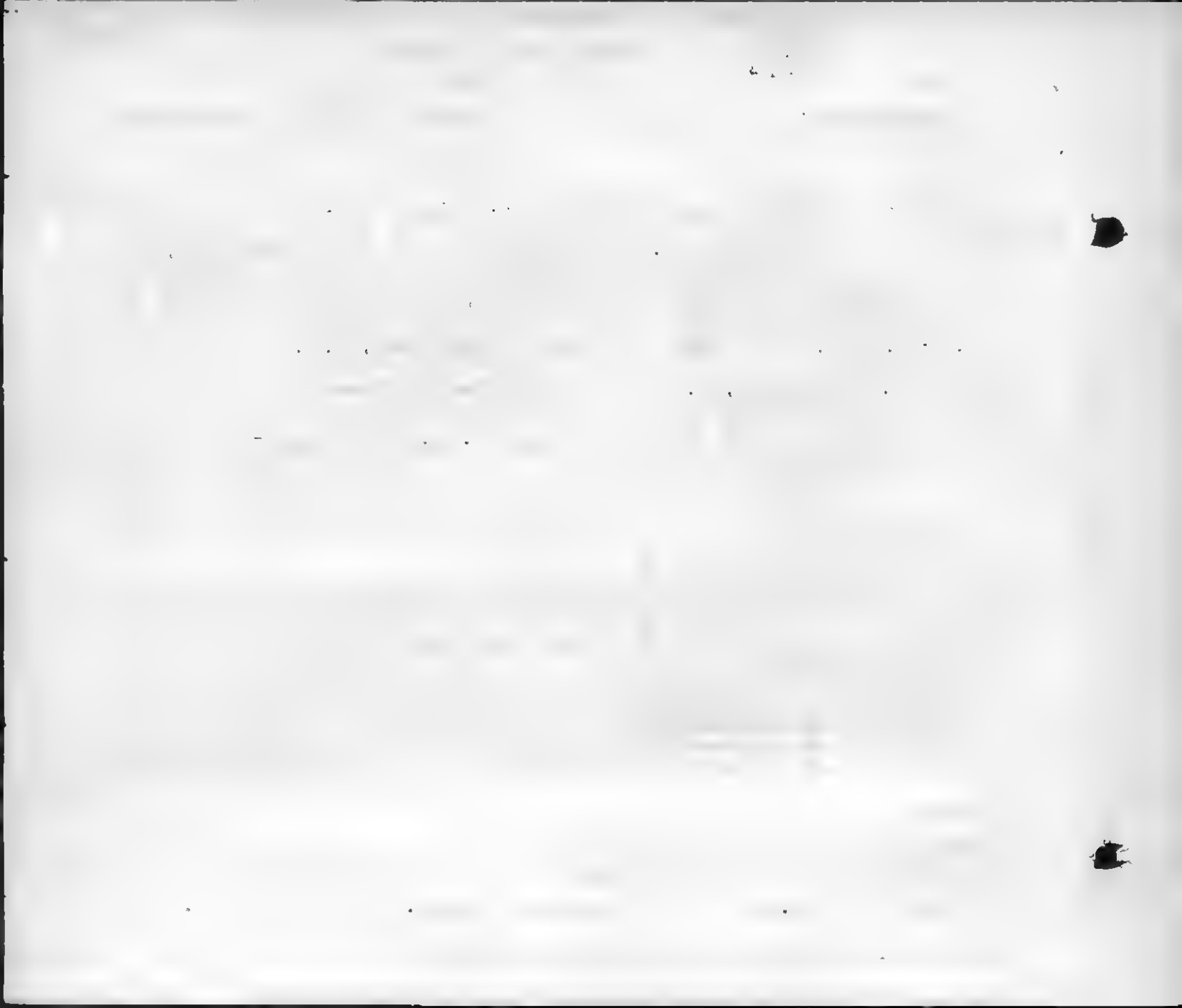
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12700**  
**CERTIFICATE OF DEATH**

**12687**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Montgomery</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4905 Battery Lane</b>				d. STREET ADDRESS <b>4905 Battery Lane</b>			
3. NAME OF DECEASED (Type or print) <b>JAMES E. HUTCHINSON</b>				4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1878</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>21</b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Pat. Atty.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>James E. Hutchinson, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Randall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. J. E. Hutchinson—same as #2 wife</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute dilatation of heart</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>congestive failure &amp; H &amp; V type heart</b> DUE TO (c) <b>myocardial infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>2 yrs.</b>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b></b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1935</b> to <b>11/29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/29</b> , 19 <b>58</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Emmett E. Corner</b> M.D.				ADDRESS (Street, city or town, state) <b>2601 Woodley Pl NW</b> DATE SIGNED <b>11/29/58</b>			
PHYSICIAN'S NAME (Type) <b>Emmett E. Corner</b>				<b>"Park" W. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Wm S. Evans</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 48 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12701

## CERTIFICATE OF DEATH

12688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>L. J. ...</u>				d. STREET ADDRESS <u>13315 Lydia St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JENNIE G. ISACS</u>				4. DATE OF DEATH <u>Nov-16-1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN-10-1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK-NY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>MOSES GINSBURG</u>				14. MOTHER'S MAIDEN NAME <u>LINA Bloom</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>CHARLOTTE KUPPER (SANE)</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Heart Disease</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>34 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 20</u> , 19 <u>58</u> , to <u>Nov 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 16</u> , 19 <u>58</u> , and that death occurred at <u>6:40</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. L. Sullivan</u>				ADDRESS (Street, city or town, state) <u>M.D. 13000 Georgia Ave. S.W. Sp. 110</u>			
PHYSICIAN'S NAME (Type) <u>S. L. TABB</u>				DATE SIGNED <u>11/16/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Judah Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>NEW YORK-NY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dzuganovsky &amp; Sons</u> ADDRESS <u>3501-14th St. N.W. Wash DC</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	





12702

## CERTIFICATE OF DEATH

12689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>605 Sligo Avenue</b>		d. STREET ADDRESS <b>605 Sligo Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>Iseli</b> Last <b>Iseli</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>1</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/91</b>
9. AGE (In years last birthday) <b>67 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	11. BIRTHPLACE (State or foreign country) <b>SWITZERLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN FICHTER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>577-01-8799</b>		17. INFORMANT <b>Mrs. Marie R. Iseli, 605 Sligo Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Right hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Hypertension</b> (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>Undetermined</b> <b>Undetermined</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 11, 1954</b> to <b>Nov 1, 1958</b> that I last saw the deceased alive on <b>Nov 1, 1958</b> and that death occurred at <b>10:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George L Ball</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7835 Eastern Ave Nov 2, 1958</b>	
PHYSICIAN'S NAME (Type) <b>George L Ball</b>		<b>Silver Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>11/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGES COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER L. PUMPHREY, INC.</b> <b>Raymond D. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12609

## CERTIFICATE OF DEATH

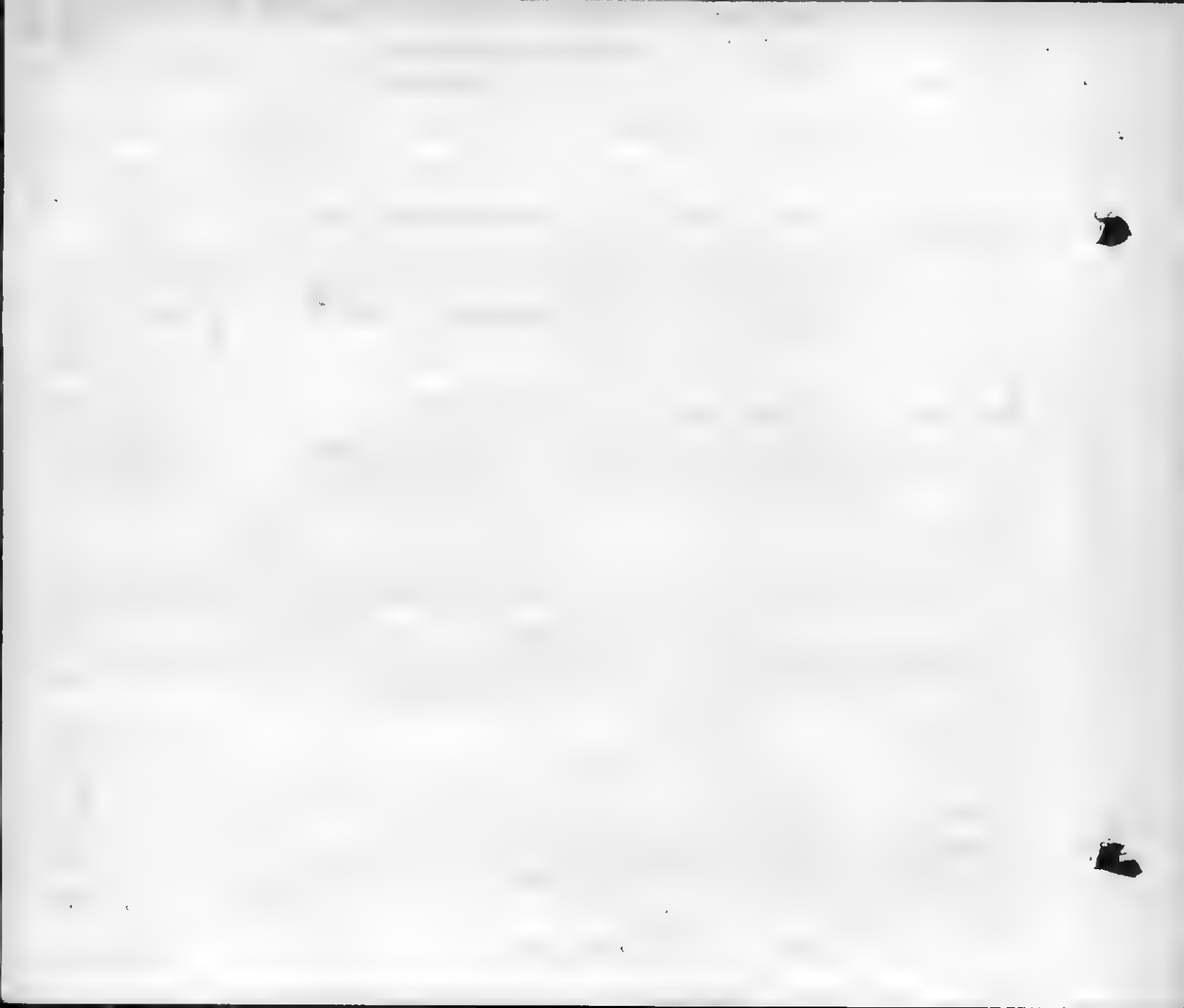
12690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK 12</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLLEGE PARK, MARYLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN &amp; HOSP.</b>				d. STREET ADDRESS <b>3120 POWDER MILL RD</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA AMELIA JACKSON</b>				4. DATE OF DEATH Month Day Year <b>11 - 10 1958</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-67</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>	
13. FATHER'S NAME <b>MR. MORGLE</b>			14. MOTHER'S MAIDEN NAME <b>ELIZA. Part name not known</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>WASHINGTON SAN &amp; HOSP. RECORDS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>434.1 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Age - 90 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July</b> , 1938, to <b>11-10</b> , 1958, that I last saw the deceased alive on <b>11-10</b> , 1958, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7600 E. Annapolis Ave. Baltimore, Md.</b> ACTUAL SIGNATURE <b>A. E. POYNE</b> M.D. PHYSICIAN'S NAME (Type) <b>A. E. POYNE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12610** **CERTIFICATE OF DEATH**

**12691**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILMINGTON PARK</u> c. LENGTH OF STAY IN TB <u>14 1/2 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WILMINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HENDERSON</u> d. STREET ADDRESS <u>835 W 2nd Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Arthur</u> Middle <u>TOMKINS</u> Last <u>LILLIE</u>			<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>15</u> Year <u>1958</u>																							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>																						
<b>8. DATE OF BIRTH</b> <u>11/17/19</u>		<b>9. AGE</b> (In years last birthday) <u>38</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2"><b>IF UNDER 1 YEAR</b></td> <td colspan="2"><b>IF UNDER 24 HRS.</b></td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>		Months	Days	Hours	Min.															
<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>																								
Months	Days	Hours	Min.																							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>1</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Wilmington</u>																						
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>American</u>			<b>13. FATHER'S NAME</b> <u>Arthur Tomkins</u>																							
<b>14. MOTHER'S MAIDEN NAME</b> <u>Lillie Hamilt.</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2"><b>16. SOCIAL SECURITY NO</b></td> <td colspan="2"><b>17. INFORMANT</b></td> </tr> <tr> <td colspan="2"><u>46</u></td> <td colspan="2"><u>His leg record</u></td> </tr> </table>			<b>16. SOCIAL SECURITY NO</b>		<b>17. INFORMANT</b>		<u>46</u>		<u>His leg record</u>														
<b>16. SOCIAL SECURITY NO</b>		<b>17. INFORMANT</b>																								
<u>46</u>		<u>His leg record</u>																								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart</u> DUE TO (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u> DUE TO (d) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>																										
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																										
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2"><b>20c. TIME OF INJURY</b></td> <td colspan="2"><b>20d. INJURY OCCURRED</b></td> <td colspan="2"><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)</td> </tr> <tr> <td>Hour</td> <td>Month, Day, Year</td> <td>While at work</td> <td>Not while at work</td> <td colspan="2"></td> </tr> <tr> <td></td> <td><u>19</u></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2"></td> </tr> </table>			<b>20c. TIME OF INJURY</b>		<b>20d. INJURY OCCURRED</b>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		Hour	Month, Day, Year	While at work	Not while at work				<u>19</u>	<input type="checkbox"/>	<input type="checkbox"/>			<b>20f. (City or town)</b> (County) (State) <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td><u>Wilmington</u></td> <td><u>Delaware</u></td> <td><u>DE</u></td> </tr> </table>			<u>Wilmington</u>	<u>Delaware</u>	<u>DE</u>
<b>20c. TIME OF INJURY</b>		<b>20d. INJURY OCCURRED</b>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)																						
Hour	Month, Day, Year	While at work	Not while at work																							
	<u>19</u>	<input type="checkbox"/>	<input type="checkbox"/>																							
<u>Wilmington</u>	<u>Delaware</u>	<u>DE</u>																								
<b>21. I certify that I attended the deceased from</b> <u>Nov 15, 1958</u> , <b>to</b> <u>Nov 15, 1958</u> , <b>that I last saw the deceased alive on</b> <u>Nov 15, 1958</u> , <b>and that death occurred at</b> <u>7 M.</u> <b>from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <u>Wilmington, Delaware</u> <b>DATE SIGNED</b> <u>Nov 15, 1958</u>																										
<b>ACTUAL SIGNATURE</b> <u>Thomas L. Carroll</u> <b>M.D.</b> <u>Nov 15, 1958</u>																										
<b>PHYSICIAN'S NAME (Type)</b> <u>Thos L Carroll</u>																										
<b>22a. BURIAL, CREMATION, OR OTHER DISPOSAL</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Nov 17, 58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Luke's</u>																						
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Wilmington, DE</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Carroll</u> <b>ADDRESS</b> <u>251 Carroll St. W. H. H.</u>																								
<b>24a. REC'D BY REGISTRAR</b> <u>Nov 18 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>William S. Thomas</u>																								

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



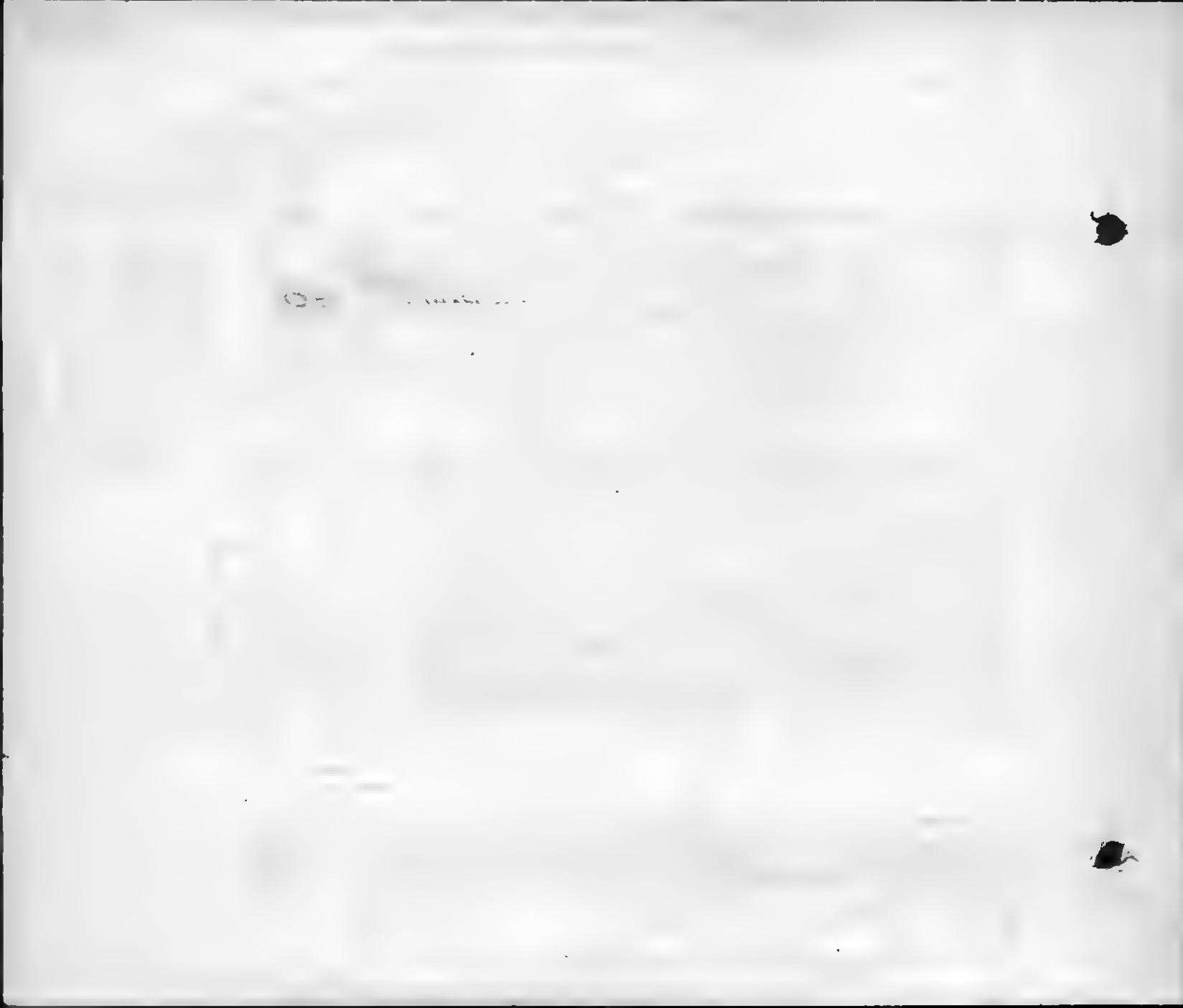
12692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admn. adn. adn.) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN lb <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Russell Nursing Home</u>		e. STREET ADDRESS <u>Rt. 40</u>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Carter</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1905</u>
9. AGE (In years) <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
13. BIRTHPLACE (State or foreign country) <u>Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>John Henry Johnson</u>		16. MOTHER'S MAIDEN NAME <u>Celia (unknown)</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO <u>Unknown</u>	
19. INFORMANT <u>Brother</u>		20. ADDRESS <u>Ellicott City</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Cerebral Embolism</u> 302X DUE TO <u>Auricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Essential</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		24. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
25. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>a. m.</u> p. m. <u>  </u>		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
27. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
28. I certify that I attended the deceased from <u>2-2-58</u> , 19 <u>58</u> , to <u>11-15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-15</u> , 19 <u>58</u> , and that death occurred at <u>5:15</u> M. from the causes and on the date stated above		29. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>	
30. ACTUAL SIGNATURE <u>Clive E. Jackson</u> M.D. <u>R.D. 1, Gaithersburg, Md.</u>			
31. PHYSICIAN'S NAME (Type) <u>  </u>			
32. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		33. DATE THEREOF <u>11-18-58</u>	
34. NAME OF CEMETERY OR CREMATORY <u>ST LOUIS</u>		35. LOCATION (City, town or county) (State) <u>CLARKSVILLE Md</u>	
36. FUNERAL DIRECTOR'S SIGNATURE <u>Edna K. Johnson</u> ADDRESS <u>Ellicott City</u>		37. REC'D BY REGISTRAR <u>  </u> DATE <u>NOV 18 '58</u>	
38. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
19M 9/55





12704

## CERTIFICATE OF DEATH

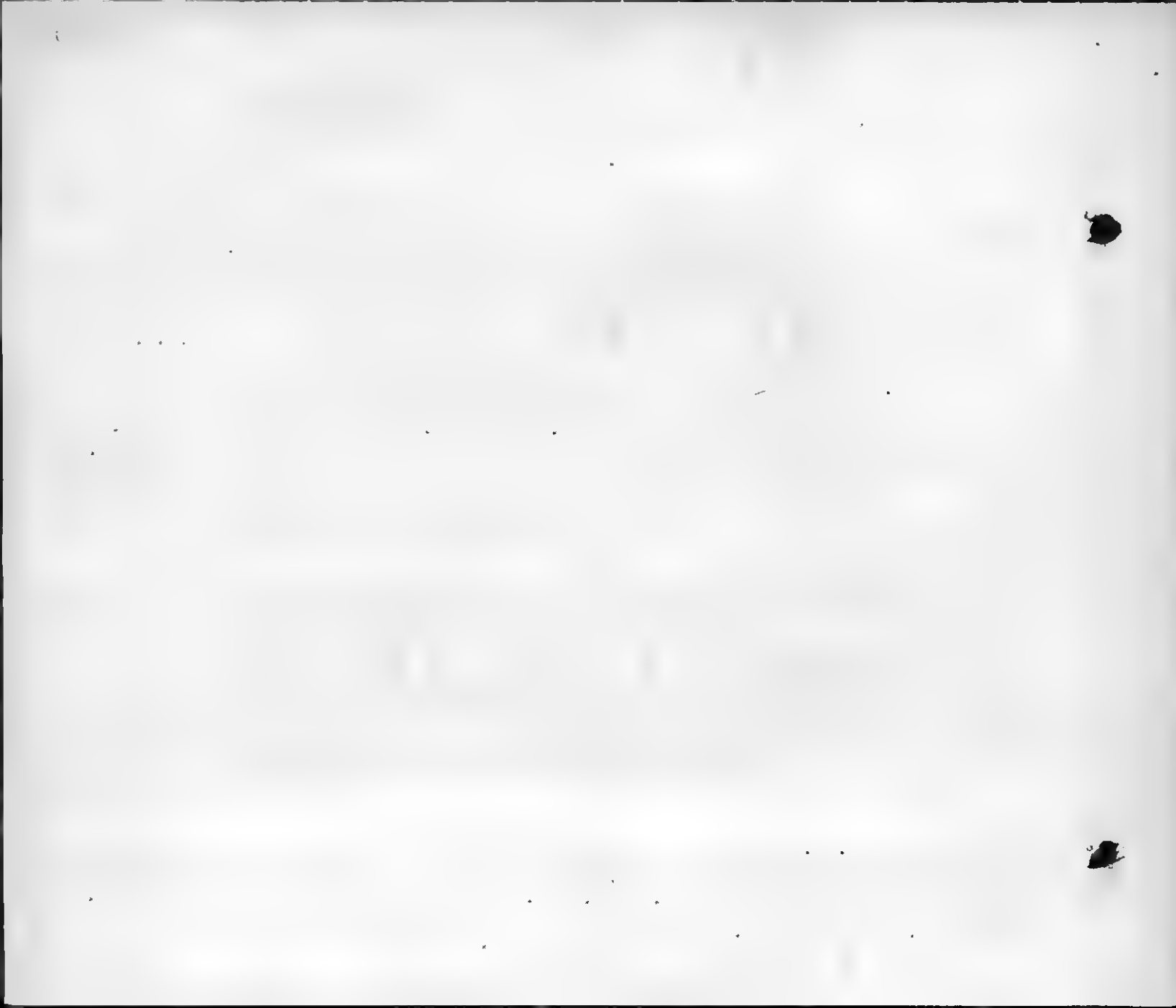
12693

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN IB 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9412 Flower Avenue				d. STREET ADDRESS 9412 Flower Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last BESSIE TEMPERANCE JOHNSTON				4. DATE OF DEATH Month NOV. Day 13 Year 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/79	
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME THOMAS N. SCHROYER				14. MOTHER'S MAIDEN NAME TOBITHA RAMSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Herbert A. Johnston, 9412 Flower Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO <u>NEPHROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEP. 1957</u> to <u>NOV. 13, 1958</u> that I last saw the deceased alive on <u>13 Nov. 1958</u> and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>LBSnow</u>				DATE SIGNED <u>9/14/58</u>			
PHYSICIAN'S NAME (Type) L. B. SNOW				ADDRESS (Street, city or town, state) SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/17/58		22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23a. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. Ziska</u>				ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	
24a. REC'D BY REGISTRAR DATE NOV 17 '58							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



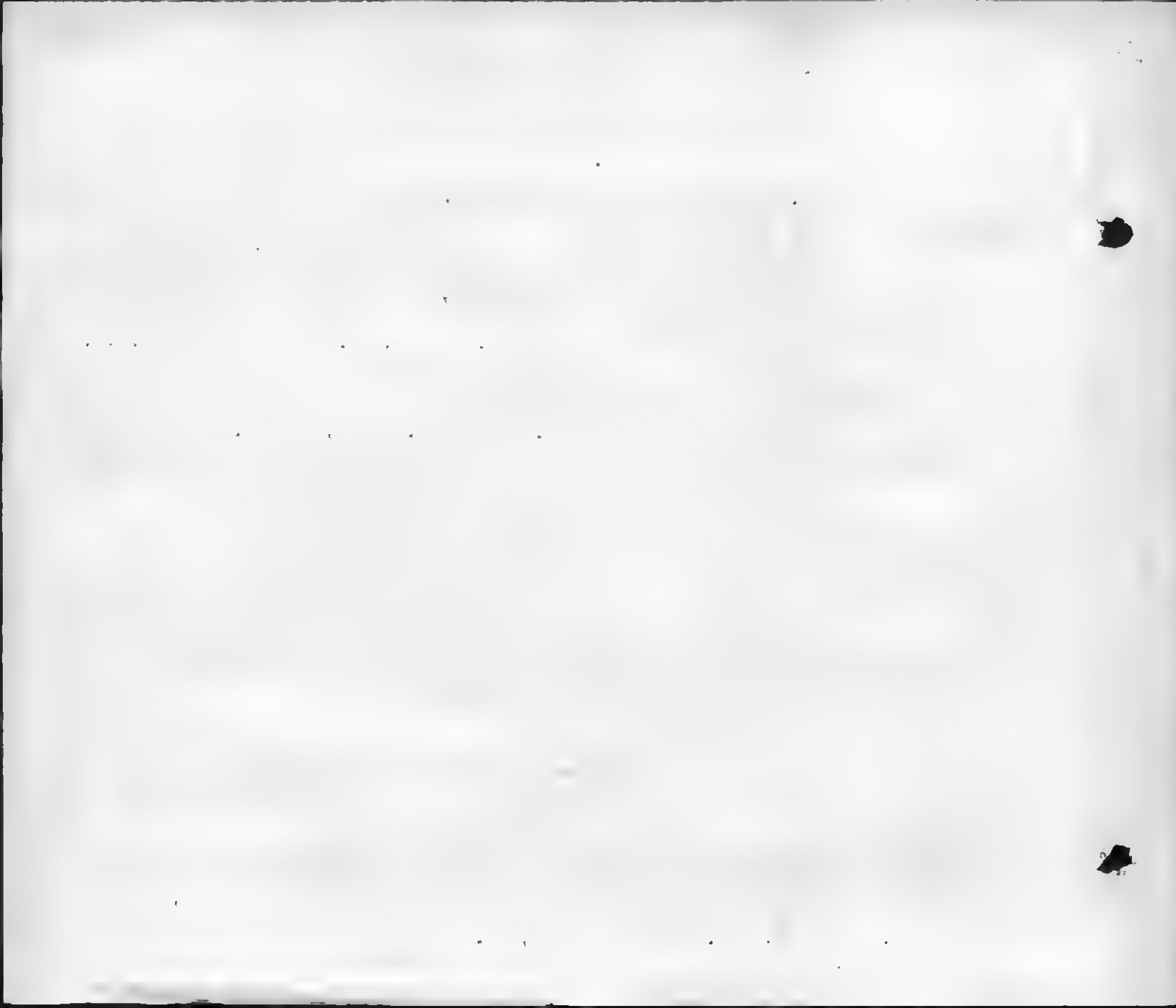
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12705**  
**CERTIFICATE OF DEATH**

**12694**

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>1012 W. Nolcrest Drive</b>				e. STREET ADDRESS <b>1012 W. Nolcrest Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>SABIN</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 9, 1886</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSURANCE BROKER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ST. JOSEPH, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES ALDRICH SABIN</b>				14. MOTHER'S MAIDEN NAME <b>MARY WELCH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Mr. Stanley S. Jones, 1012 W. Nolcrest Drive Silver Spring, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>-cardio respiratory insufficiency</b> DUE TO <b>-generalized toxemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>due to kidney insufficiency</b> DUE TO <b>chronic severe degenerative Rheumatoid arthritis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe osteoporosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Jan. 15, 1956</b> to <b>Oct 31, 1958</b> , that I last saw the deceased alive on <b>Oct. 31, 1958</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10401 N. H. Ave. Silver Spring, Maryland</b> DATE SIGNED <b>VERONICA TROOST</b>							
ACTUAL SIGNATURE <b>VERONICA TROOST</b> M.D. <b>10401 N. H. Ave. Silver Spring, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>VERONICA TROOST</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



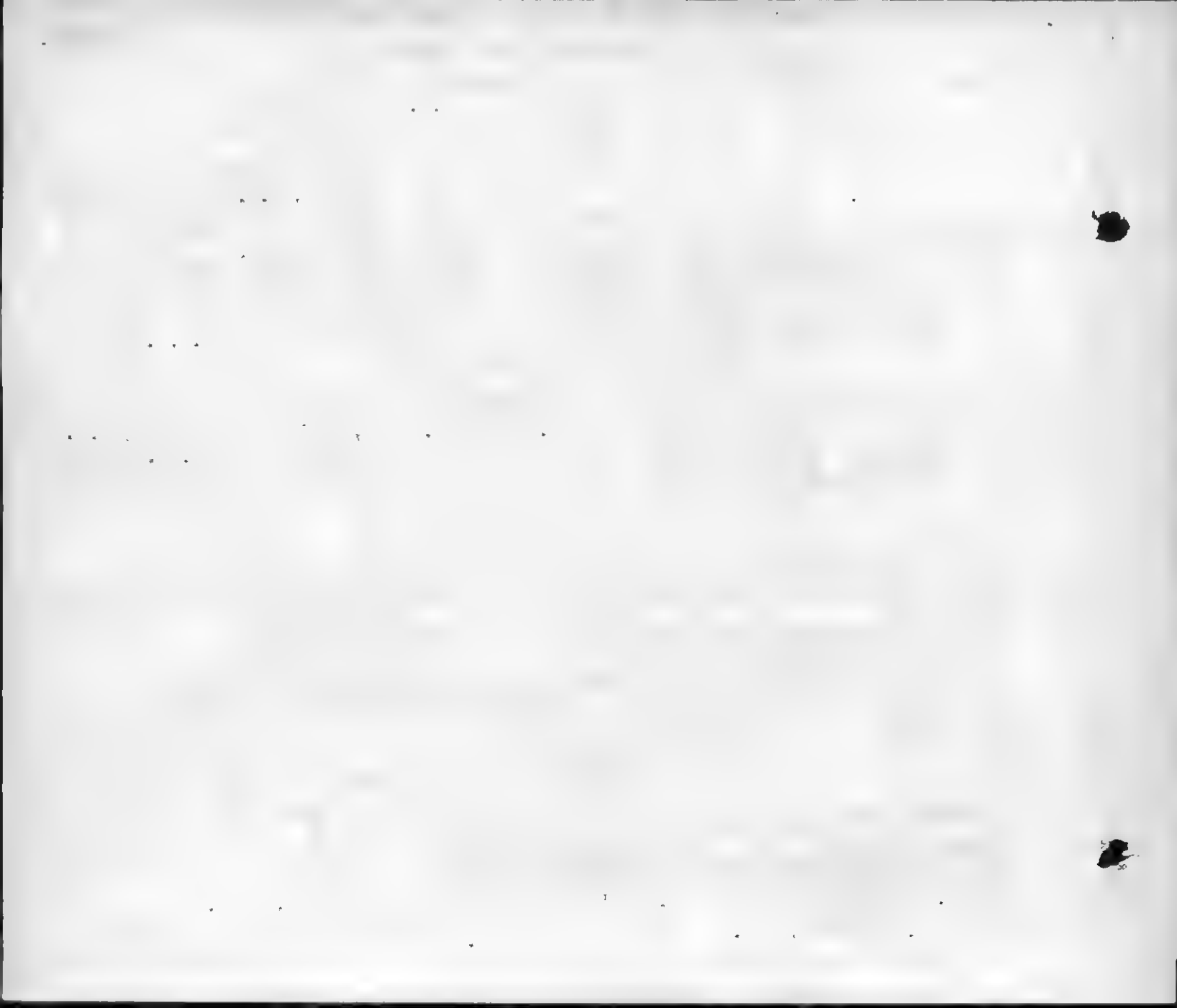
12706

CERTIFICATE OF DEATH

Reg. Dist. No. 12695

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPING</b>				c. LENGTH OF STAY IN 1b <b>7 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. PHILOMENA REST HOME</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>			
				d. STREET ADDRESS <b>3901 Langley Court, N.W.</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle Last <b>KANE</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>15</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/9/70</b>	
9. AGE (In years) <b>88</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardener (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gardening</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Patrick Kane</b>				14. MOTHER'S MAIDEN NAME <b>Bridgett Murphy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Mr. Edward F. Kane, 3901 Langley Court, N.W.</b>	
				Address <b>Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Septicemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 wks.</b> <b>approx 30 yrs.</b> <b>2 wks.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 3, 1958</b> , to <b>Nov. 15, 1958</b> , that I last saw the deceased alive on <b>Nov. 7, 1958</b> , and that death occurred at <b>2:45 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2205 Richmond St. Silver Spring, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Harry J. Kicheter</b> M.D.							
PHYSICIAN'S NAME (Type) <b>HARRY J. Kicheter</b>				<b>Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>TRANS. &amp; BURIAL</b>		<b>11/16/58</b>		<b>ST. ANN'S CATHOLIC CEMETERY</b>		<b>LENOX, MASS.</b>	
23. FURNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12696

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If Institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Rockingham</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisonburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>500 Green Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>KENNEDY</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 30 1958</u>
9. AGE (In years lost birthday) yrs <u>2</u> Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>CLEATUS LEE KENNEDY</u>		14. MOTHER'S MAIDEN NAME <u>EVELYN MARIE COCKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Sudden death</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain - 5 months gestation</u> DUE TO (c) <u>Birth weight - 1 lb. 15 oz.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/30</u> , 19 <u>58</u> , to <u>11/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>58</u> , and that death occurred at <u>5A</u> M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Dr. H. L. Latham</u> M.D. <u>Dr. H. L. Latham</u>		<u>11/30/58</u>	
PHYSICIAN'S NAME (Type) <u>Harrisonburg, Va.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 1</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville, Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Barber</u>		24a. REC'D BY REGISTRAR <u>DATE DEC 2 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>





## CERTIFICATE OF DEATH

12697

Reg. Dist. No.

1. PLACE OF DEATH  
o. COUNTY HORTHGENTRY MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institutions: Residence before admission)  
o. STATE VIRGINIA b. COUNTY ROCKINGHAM

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARRISONBURG

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL d. STREET ADDRESS 500 GREEN ST. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last BABY GIRL KENNEDY 4. DATE OF DEATH Month Day Year NOVEMBER 30 1958

5. SEX FEMALE 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH November 30 1958 9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR Months Days 2 IF UNDER 24 HRS. Hours Min 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME CLEATUS LEE KENNEDY 14. MOTHER'S MAIDEN NAME ERLYN MARIE COOKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO — 17. INFORMANT Address MOTHER

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 776X DUE TO Asphyxia - suffocation  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to infant - ill & 803.  
(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 11 20d. INJURY OCCURRED While ☒ Not while ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 30, 1958, to Nov 30, 1958, that I last saw the deceased alive on Nov 30, 1958, and that death occurred at 54 M, from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) 26 N. Summit St. Baltimore, Md. DATE SIGNED 11/30/58

ACTUAL SIGNATURE W. H. Lenthorn M.D. W. H. Lenthorn, Jr.  
PHYSICIAN'S NAME (Type) Baltimore, Md.

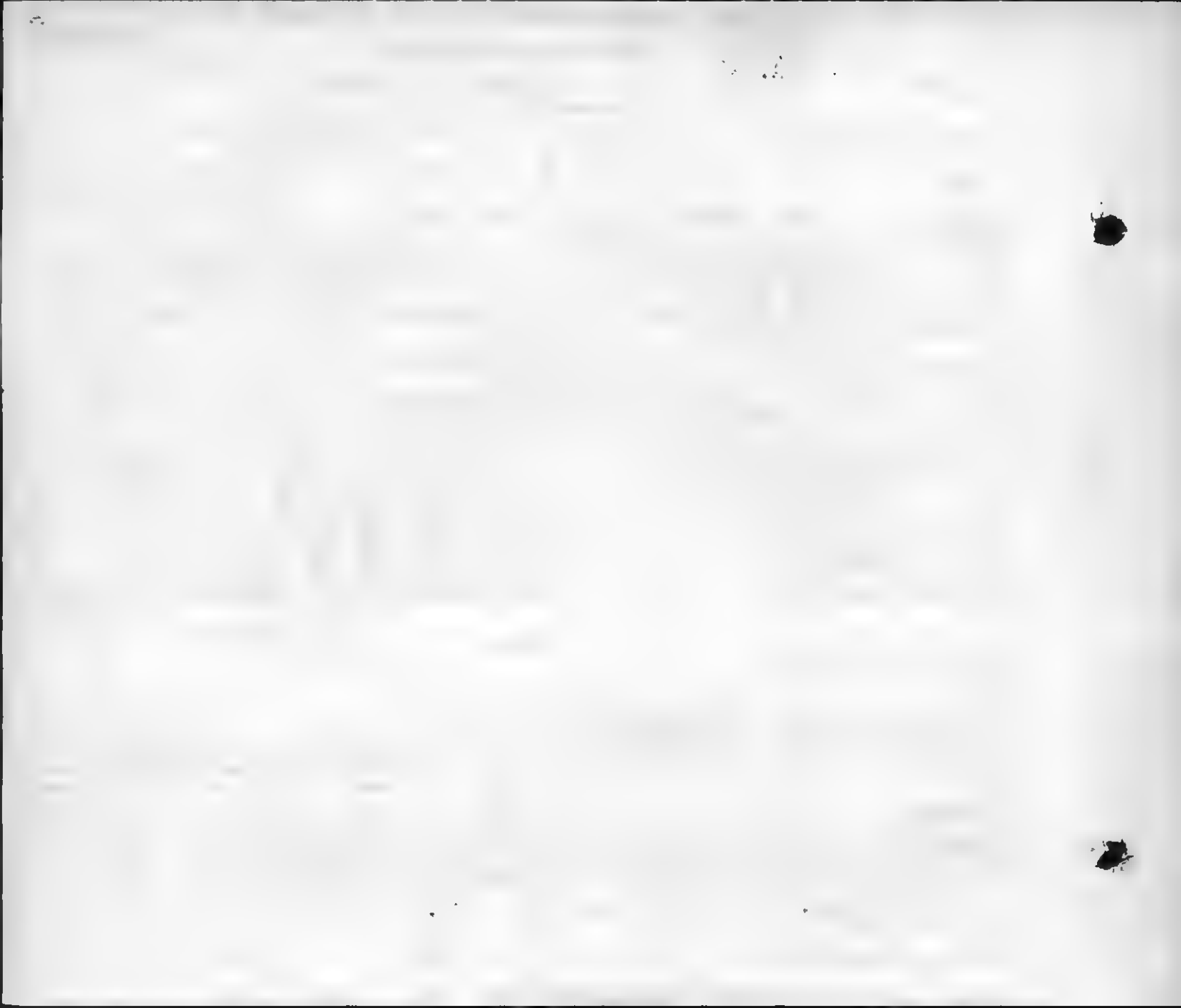
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Dec. 1 22c. NAME OF CEMETERY OR CREMATORY Laytonville, Md. 22d. LOCATION (City, town, or county) (State) Laytonville, Md

23. FUNERAL DIRECTOR'S SIGNATURE Woyce Barber, Laytonville, Md ADDRESS — 24a. REC'D BY REGISTRAR DATE DEC 2 '58 24b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12709

## CERTIFICATE OF DEATH

12698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>194 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium.</u>				d. STREET ADDRESS <u>83x-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Cecelia</u> Middle <u>L.</u> Last <u>Kent</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 2, 1880</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>15</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
13. FATHER'S NAME <u>Charles Jacques Loizeux</u>				14. MOTHER'S MAIDEN NAME <u>Oliver Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Chart. Carleton Kent-4609 S. 3419 St.</u>			
17. INFORMANT <u>Chart. Carleton Kent-4609 S. 3419 St.</u>				Address <u>Arlington, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO <u>10 yrs</u> (c) <u>1 day</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured L. Femur</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>o m.</u> <u>p. m.</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>53</u> , to <u>11-20-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-19-58</u> , 19 <u>58</u> , and that death occurred at <u>12:30 P.</u> M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>915 19TH ST NW</u>			
ACTUAL SIGNATURE <u>Lewis H. Bibben</u>				DATE SIGNED <u>11/20/58</u>			
PHYSICIAN'S NAME (Type) <u>LEWIS H. BIBBEN</u>				<u>WASHINGTON DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>Nov 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH F. BURCHAKSONS</u>				ADDRESS <u>3034 M ST NW</u>			
24a. REC'D BY REGISTRAR <u>NOV 24 58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12611

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Md. Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. SAN. &amp; Hospt.</b>				d. STREET ADDRESS <b>9211 Wire Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM GILBERT KERR</b>				4. DATE OF DEATH Month Day Year <b>Nov 15 1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Jun 27, 1876</b>	9. AGE (In years last birthday) <b>82 yrs</b>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Harold J. Kerr</b>				14. MOTHER'S MAIDEN NAME <b>Clara Gilbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <b>Yes Sp. Amer.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hosp. Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Interosseous Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 h.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>August 1958</b> to <b>November 1958</b> , that I last saw the deceased alive on <b>Nov 14 1958</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>217 University Blvd E. Silver Spring, Md.</b> DATE SIGNED <b>11/15/58</b>							
ACTUAL SIGNATURE <b>Bernard A. Fitzgerald</b> M.D.							
PHYSICIAN'S NAME (Type) <b>BERNARD A. FITZGERALD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Morningside</b>		22d. LOCATION (City, town, or county) (State) <b>Clearfield Co., Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



12710

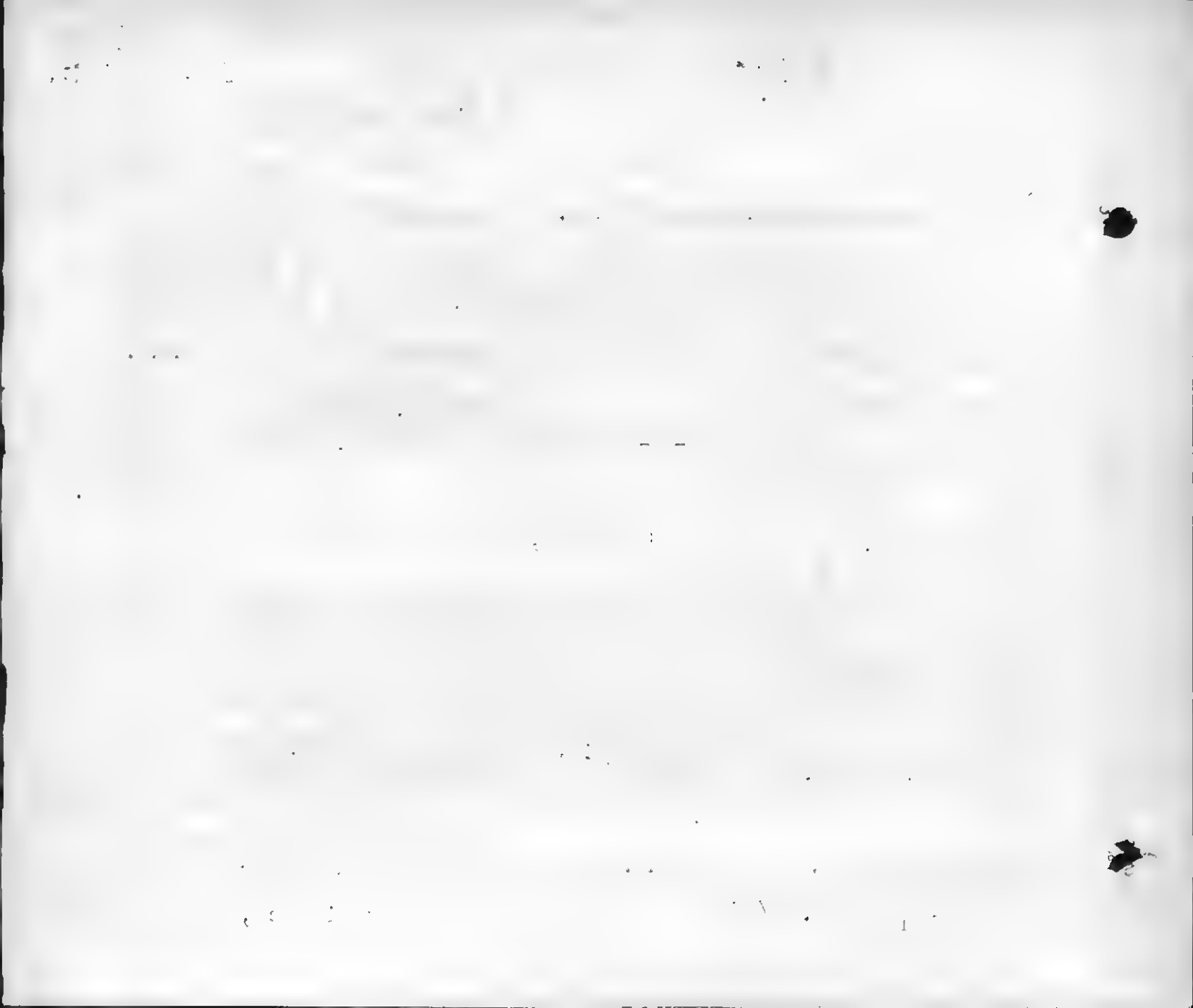
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>98 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Rhode Island</b> b. COUNTY <b>Providence</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Providence</b> d. STREET ADDRESS <b>222 Saratoga Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Francis Kerwin</b>		4. DATE OF DEATH Month Day Year <b>November 5, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1896</b>
9. AGE (in years last birthday) <b>62</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motor Stripper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electric</b>	
11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Kerwin</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Farrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>037-01-1022</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Hodgkin's Disease, Universal</b> DUE TO (c) <b>10 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>491X</b>			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 30, 1958</b> , to <b>November 5, 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> , and that death occurred at <b>2:05 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>11/5/58</b>			
ACTUAL SIGNATURE <b>Harold R. Silberman</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>HAROLD R. SILBERMAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 10/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Providence, Rhode Island</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson Co.</b>		ADDRESS <b>1300-N. Street N.W.</b> <b>Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12711

## CERTIFICATE OF DEATH

12701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 Mo.--22 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alvin</b> Middle <b>C.</b> Last <b>Ketcham</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>16</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 2, 1896</b>	
9. AGE (In years last birthday) <b>62</b> yrs		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>14</b> Hours <b></b> Min <b></b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>			
13. FATHER'S NAME <b>H urlings Ketcham</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Farley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT <b>Phila. 44, Sister Miriam K. Dixon-Wayne Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Intracerebral Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>2. Internal Hydrocephalus</b> DUE TO (c) <b>3. Diverticulosis ( Descending &amp; Sigmoid Colon)</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rockville</b>	
20f. (City or town) <b>Rockville</b>				20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Sept 5, 1958</b> to <b>Nov. 16, 1958</b> , that I last saw the deceased alive on <b>Nov. 15, 1958</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur F. Woodward</b>				ADDRESS (Street, city or town, state) <b>Rockville - Md</b> DATE SIGNED <b>11/16/58</b>			
PHYSICIAN'S NAME (Type) <b>Arthur F. Woodward</b>				<b>Rockville, Maryland</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 19 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>John L. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12612

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>111 GRANT AVENUE</b>		e. STREET ADDRESS <b>111 GRANT AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>KIESELHORST</b> Last		4. DATE OF DEATH Month <b>NOV.</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/8/85</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>HEIDELBERG, GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>GERMANY</b>	
13. FATHER'S NAME <b>WILHELM KIESELHORST</b>		14. MOTHER'S MAIDEN NAME <b>AUGUSTA (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Eleanor Anna Wilson, 111 Grant Ave. Takoma Park, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sudden</b> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>11/18/58</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/20/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NAT'L. CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		ADDRESS <b>SILVER SPRING, MD.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A1SME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

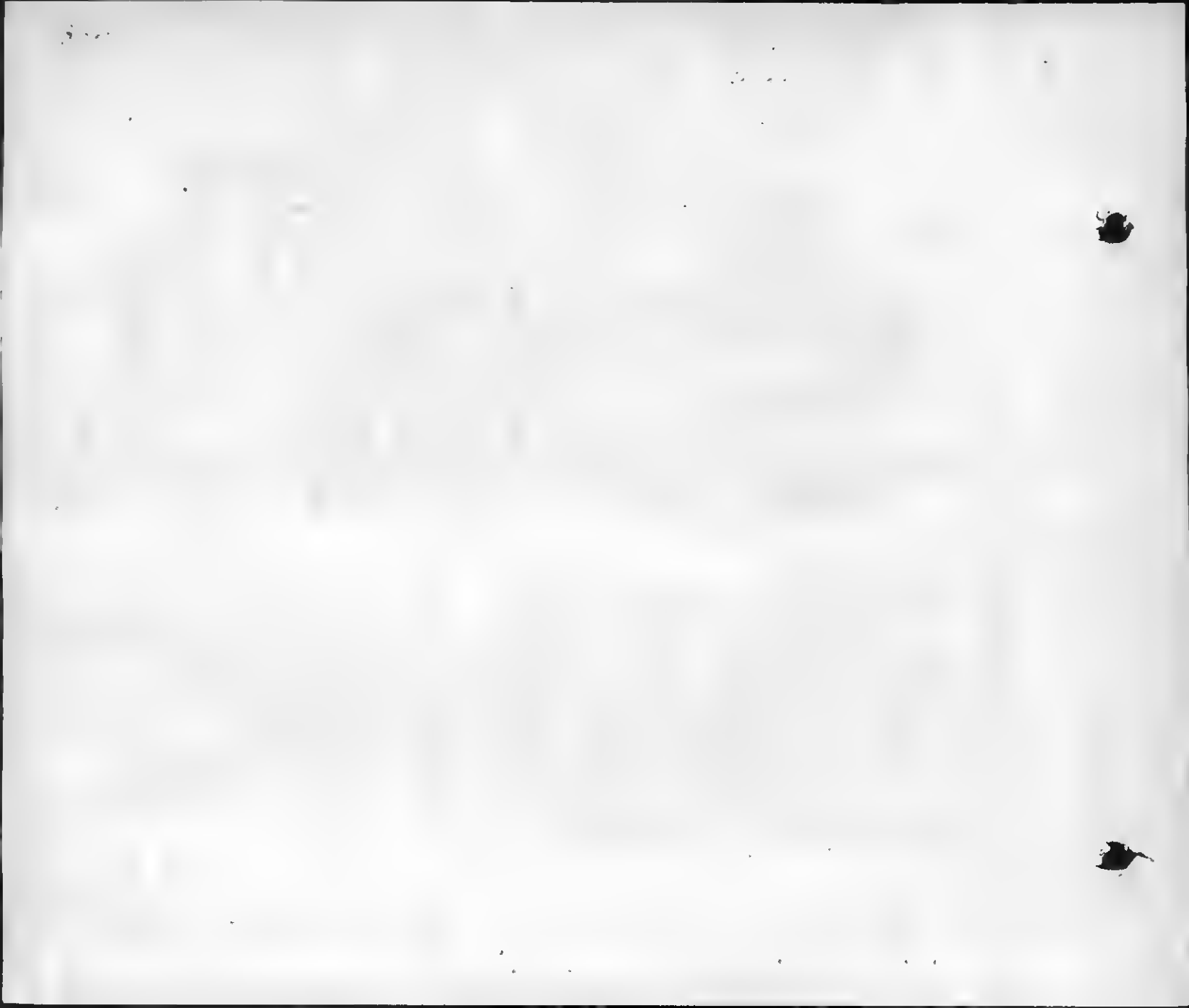
12703

Item 2, Film 6236, 12/5/58 for

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> D.C. b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>5 yrs</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens San.</u>	
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>Kimball</u> Last		4. DATE OF DEATH <u>Nov. 28, 1958</u> Year <u>19</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/1872</u> 9. AGE (In years last birthday) <u>86</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Idaho</u>	
11. BIRTHPLACE (State or foreign country) <u>Idaho</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Spaulding</u>		14. MOTHER'S MAIDEN NAME <u>Anne Allmon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>Sanatarium Records</u>	
17. INFORMANT <u>Sanatarium Records</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>170x</u> IMMEDIATE CAUSE (a) <u>Sarcoma of left breast with metastasis</u> DUE TO (b) <u>170x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>170x</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/ 28/ 58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12/1/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pasadena, California</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE 1 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12713

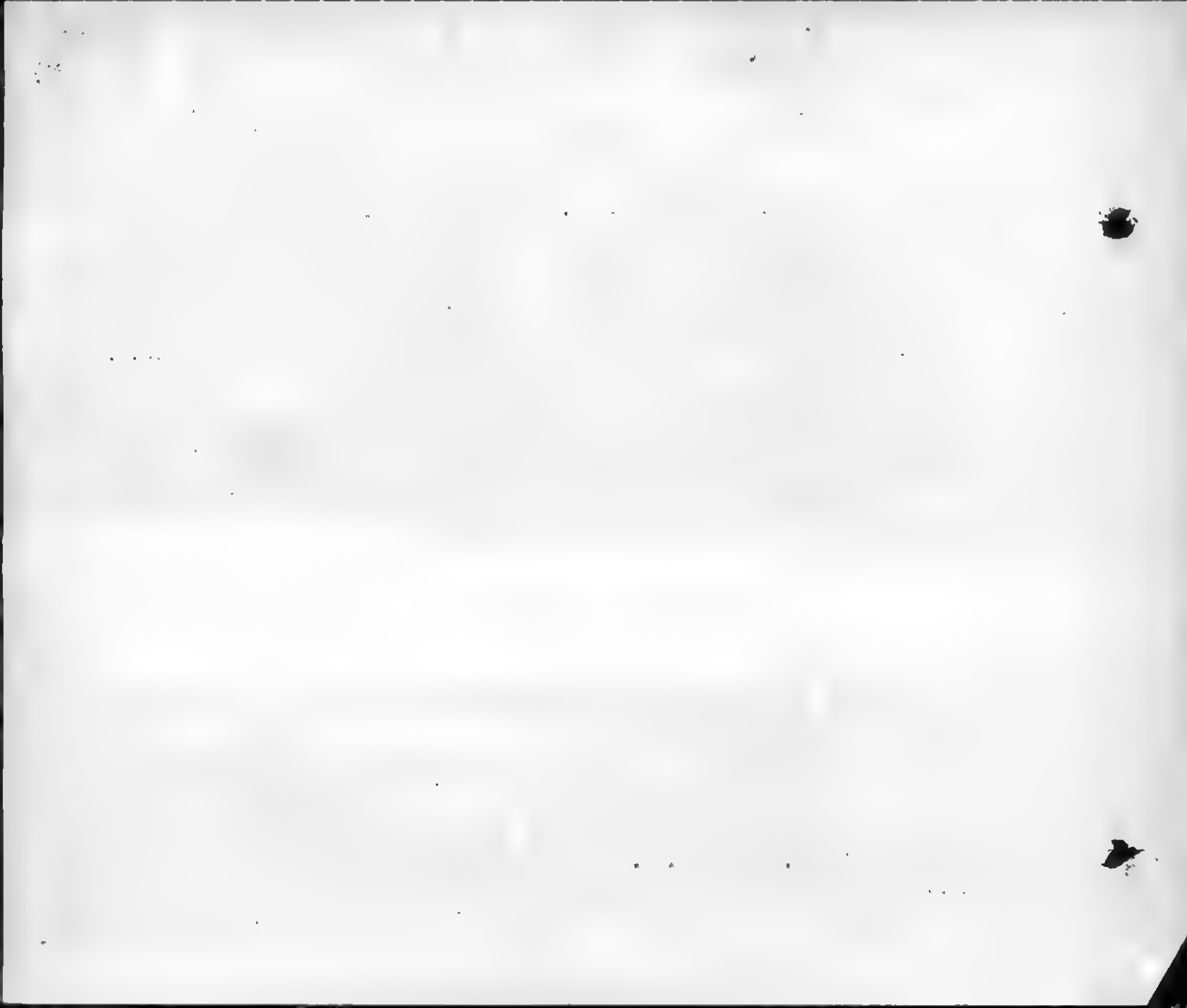
## CERTIFICATE OF DEATH

12704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Route #2, Ridge Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Gregory</b> Middle <b>George</b> Last <b>Kotishion</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1950</b>
9. AGE (In years last birthday) yrs. <b>8</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b> Hours <b>19</b> Min <b>58</b>	IF UNDER 24 HRS Months <b>8</b> Days <b>18</b> Hours <b>19</b> Min <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Kotishion</b>		14. MOTHER'S MAIDEN NAME <b>Norma Austin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RT. ventricular failure</b> 754- DUE TO (b) <b>Cardiac surgery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>multiple congenital cardiac anomalies</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>8 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 16, 1958</b> , to <b>November 18, 1958</b> , that I last saw the deceased alive on <b>November 18, 1958</b> , and that death occurred at <b>1:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William W. Pfaff</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>11/18/58</b>	
PHYSICIAN'S NAME (Type) <b>William W. Pfaff M.D.</b>		ADDRESS <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. DATE OF REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-21-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS UKRAINIAN GREEK CATH. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>McAdoo, PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Green Funeral Home</b>		ADDRESS <b>Herndon Va.</b>	
24a. REC'D BY REGISTRAR <b>NOV 20 1958</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. 8 Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





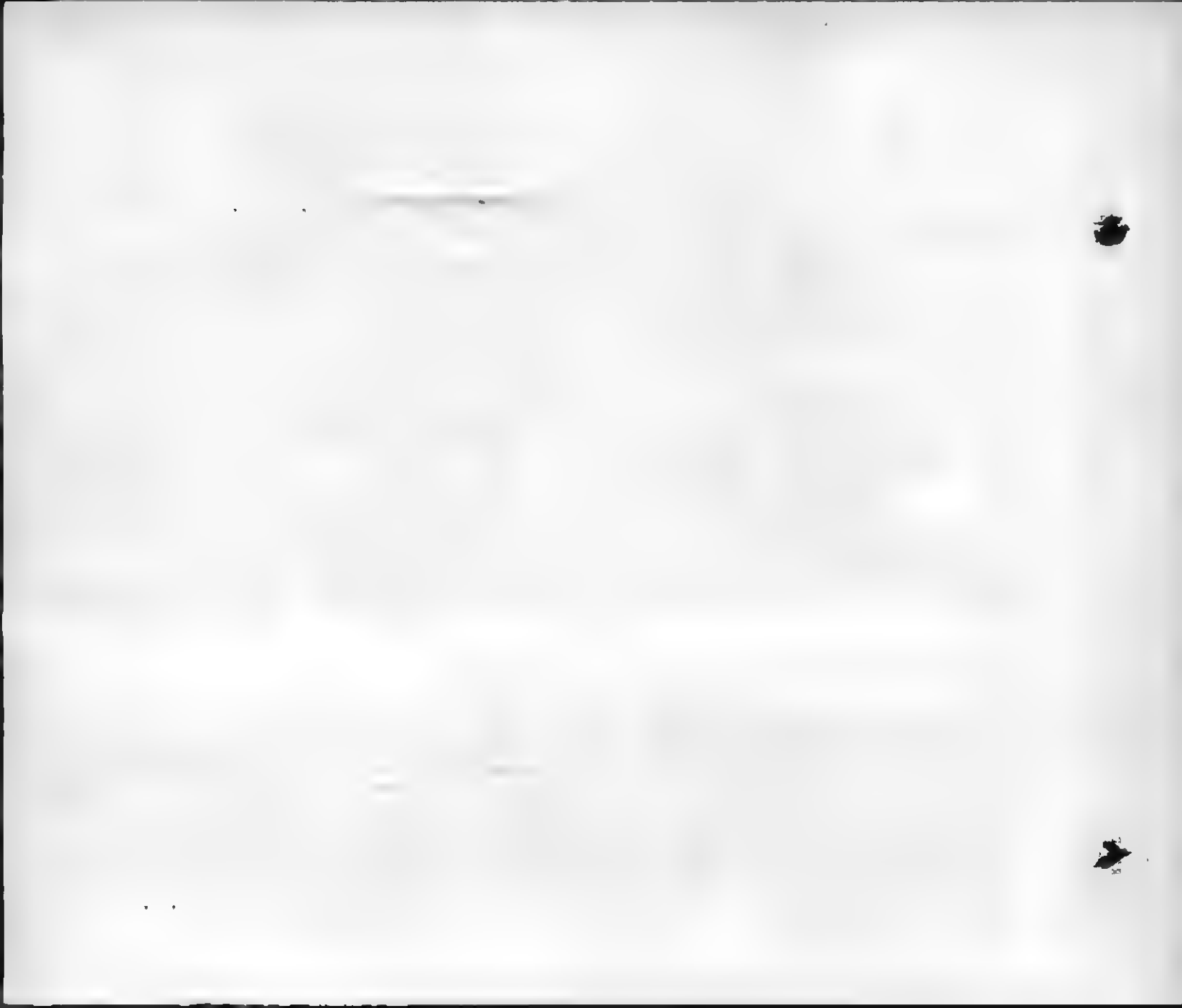
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12613**  
**CERTIFICATE OF DEATH**

**12705**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park - 12 Wash</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY IN 1b <u>9 mo.</u>				d. STREET ADDRESS <u>3292 Chestnut St. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp. T.P. 12</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLARENCE Thomas LACY</u>				4. DATE OF DEATH <u>Nov-8</u> 1958			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-'71</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder - retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William Henry Lacy</u>				14. MOTHER'S MAIDEN NAME <u>Annie Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis - R + the L</u> DUE TO <u>Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bacteremia</u> DUE TO <u>Diabetes</u> (c) <u>Probable malnutrition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable malnutrition</u> INTERVAL BETWEEN ONSET AND DEATH <u>4-5 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/9/58</u> to <u>11/8/58</u> that I last saw the deceased alive on <u>11/8/58</u> and that death occurred at <u>12 PM</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7600 Carroll Ave</u>				DATE SIGNED <u>11/8/58</u>			
PHYSICIAN'S NAME (Type) <u>Chas H Volleton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. A. News Co.</u> ADDRESS <u>2901-14th St. N.W. Wash., D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE NOV 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



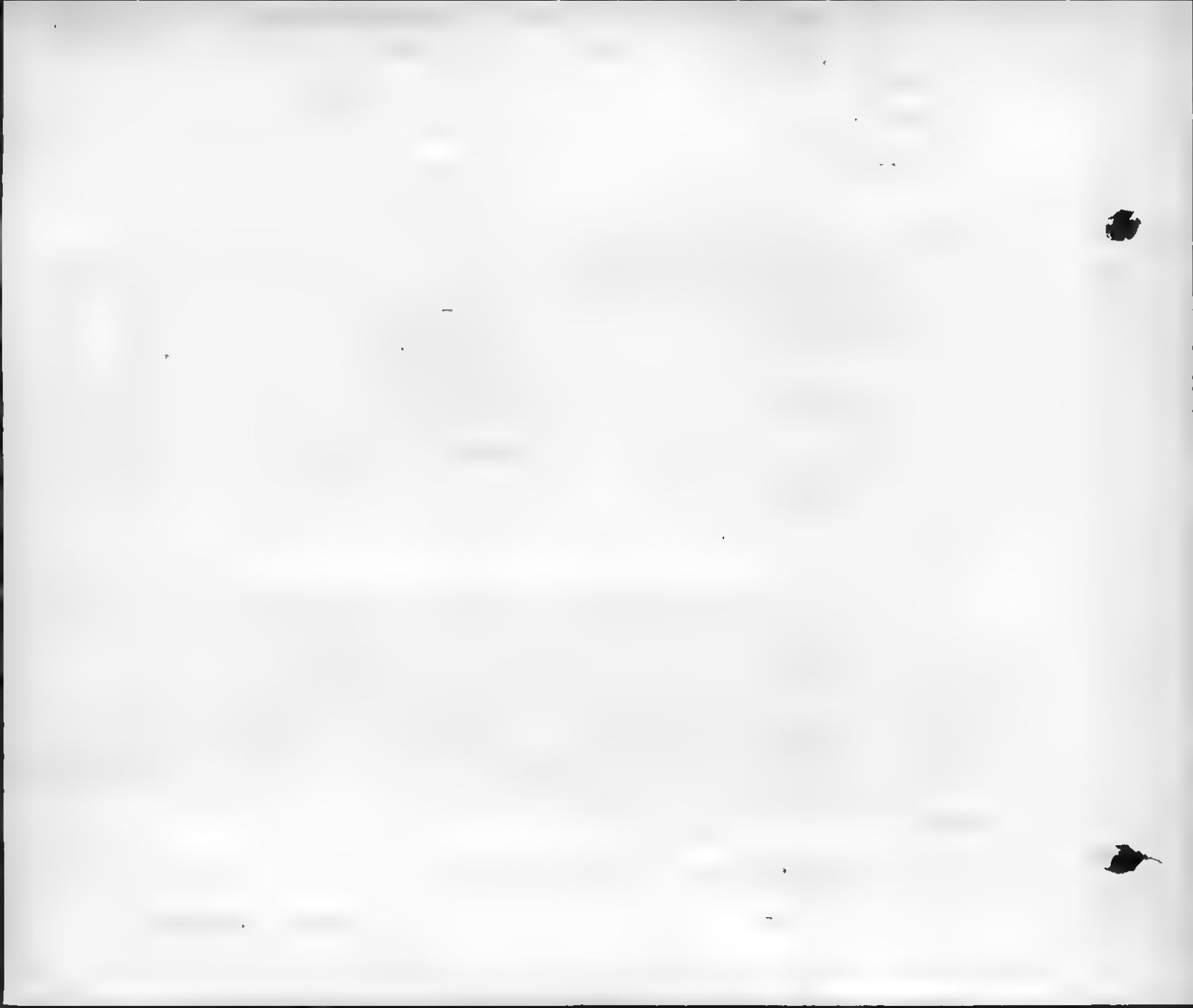
12714

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson--Rural</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson--Rural</b>		d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Viola Virginia Lambert</b>		4. DATE OF DEATH Month <b>Nov</b>		Day <b>8</b>		Year <b>1958</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9--1866</b>		9. AGE (In years last birthday) <b>92 yrs</b>		10. IF UNDER 1 YEAR Months <b>16</b>		11. IF UNDER 24 HRS Days <b>10</b>		12. IF UNDER 24 HRS Hours <b>10</b>		13. IF UNDER 24 HRS Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>		13. FATHER'S NAME <b>William Sarver</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>Wesley Lambert, Poolesville, Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO <b>arteriosclerotic Cardiovascular Disease</b> DUE TO <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Barnesville, Md</b>		(County) <b>Montgomery</b>		(State) <b>Md</b>							
21. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		22. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		23. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		24. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		25. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		26. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		27. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		28. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		29. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.		30. I certify that I attended the deceased from <b>April 1, 1958</b> to <b>8 Nov., 1958</b> , that I last saw the deceased alive on <b>8 Nov., 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon M. Smith</b>		ADDRESS (Street, city or town, state) <b>Barnesville, Md</b>		DATE SIGNED <b>9 Nov 58</b>		PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) <b>Beallsville, Maryland</b>		24a. REC'D BY REGISTRAR <b>Nov 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

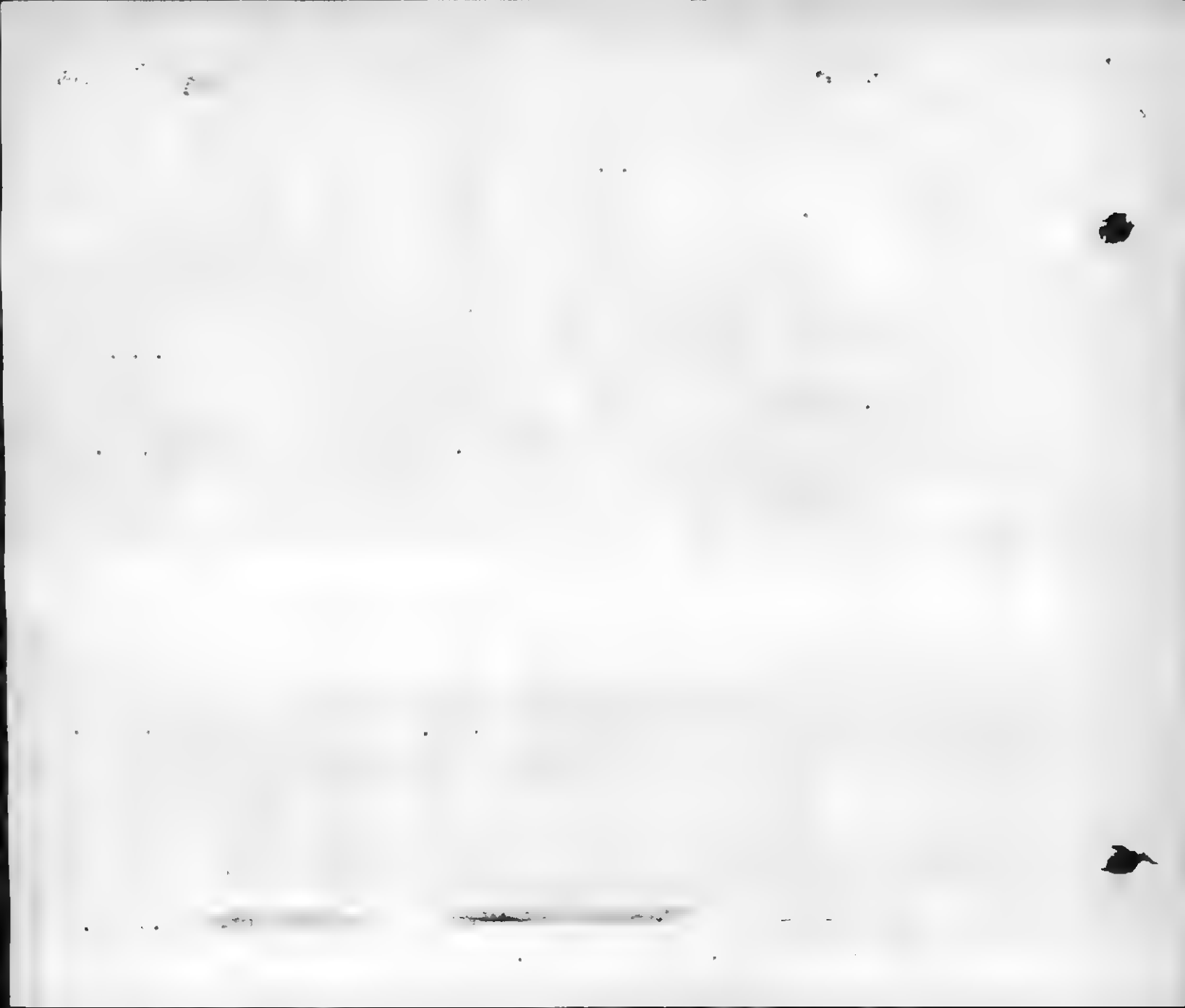
12707

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>D.O.A.</u> e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>4918 Montgomery Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Phillip</u> First Middle Last		4. DATE OF DEATH <u>November 8 19 58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1954</u>
9. AGE (in years last birthday) <u>4</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold G. Langmaid</u>		14. MOTHER'S MAIDEN NAME <u>Helen Mazza</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harold G. Langmaid</u>		Address <u>4918 Montgomery Lane Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:            (b) <u>Crushed skull</u>            DUE TO <u>Backed over by truck</u>            (c) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crushed face and fracture of left jaw</u></p>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Backed over by truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9:55</u> <u>11/8/58</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Building Devp.</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov. 8, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY ADDRESS <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hays</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 12716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3, Film G-235 11/18/58.cac

Reg. Dist. No. 215

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10421 Montrose Ave., Parkside Apts.</b>		e. STREET ADDRESS <b>10421 Montrose Ave., Parkside Apts.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Irving LEAHY</b>		4. DATE OF DEATH Month Day Year <b>November 8 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-98</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Officer-lawyer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy - Law</b>	
13. BIRTHPLACE (State or foreign country) <b>Hartford, Connecticut</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Thomas J. LEAHY</b>		16. MOTHER'S MAIDEN NAME <b>Katharine (unknown)</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1919 to 1950</b>		18. SOCIAL SECURITY NO. <b>(F) RADM Paul L Mathers, 9602 Rockville Pike</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Occlusion, right coronary artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary sclerosis, marked</b> (c) <b>slowing the underlying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Unknown</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey Funeral Home, 7557 Wisc. Ave.,</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>	
		24b. REGISTRAR'S SIGNATURE <i>Clint S. Evans</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





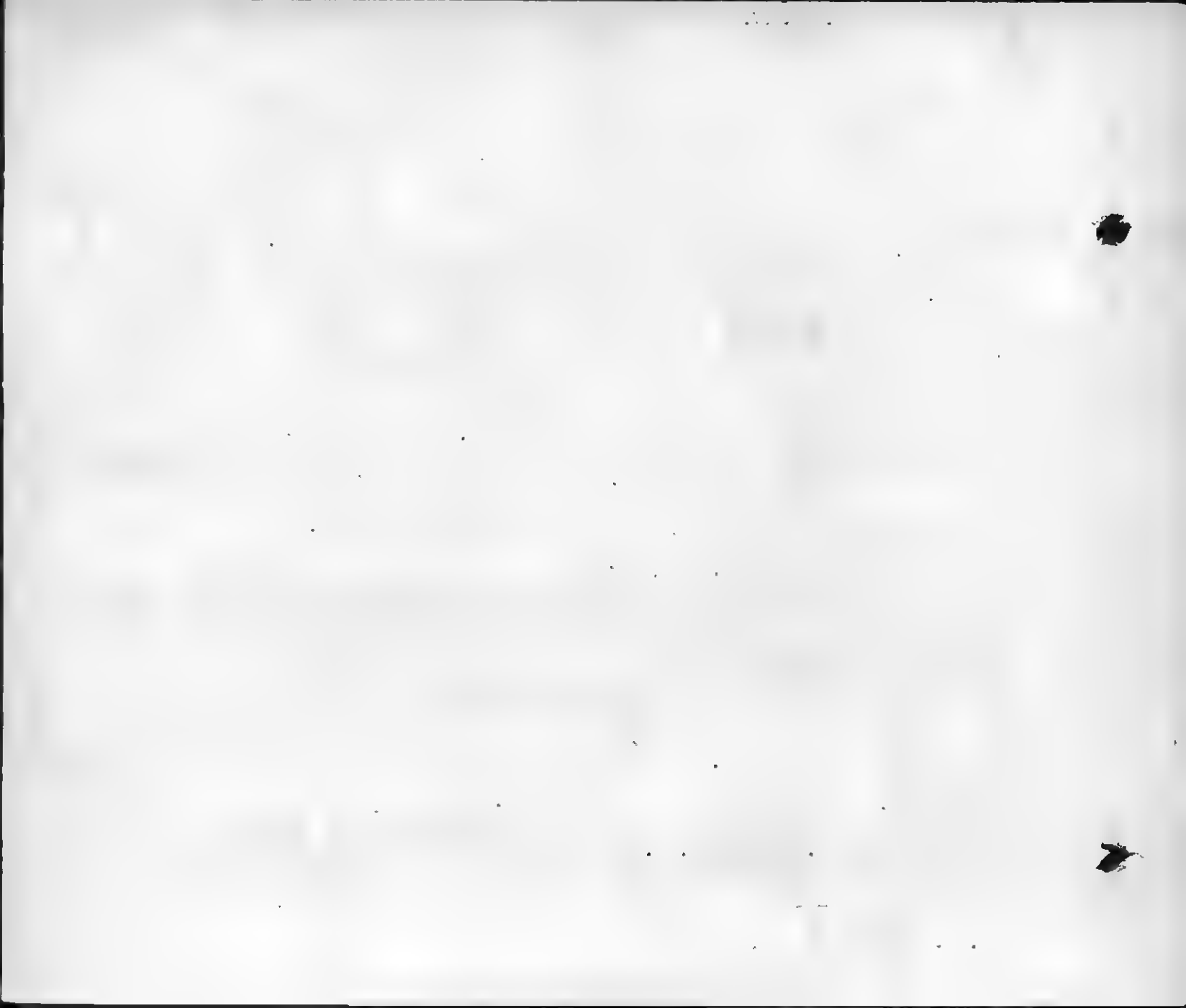
CERTIFICATE OF DEATH

12709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Airy-Rural RD#1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for the Aged</b>		d. STREET ADDRESS <b>McKaig</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NANNIE C. LEASE</b>		4. DATE OF DEATH Month Day Year <b>NOV 30 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-74</b>
9. AGE (In years last birthday) yrs <b>84</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11-7-58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COLLEGE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM H. LEASE</b>		14. MOTHER'S MAIDEN NAME <b>ANNA M. McALLISTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Austin R. Lease (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>pneumonia RT Lung</b> DUE TO <b>4</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>11-14-58</b> (c) <b>ARTEROSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11-12-58</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-21</b> , 19 <b>57</b> , to <b>11-30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-26</b> , 19 <b>58</b> , and that death occurred at <b>9:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>10128 CEDAR LAKE KENSINGTON, MD 11-30-58</b>			
ACTUAL SIGNATURE <b>Sarah E. Glover</b>		M.D. <b>10128 CEDAR LAKE KENSINGTON, MD</b>	
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-3-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 2 58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Sarah E. Glover</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

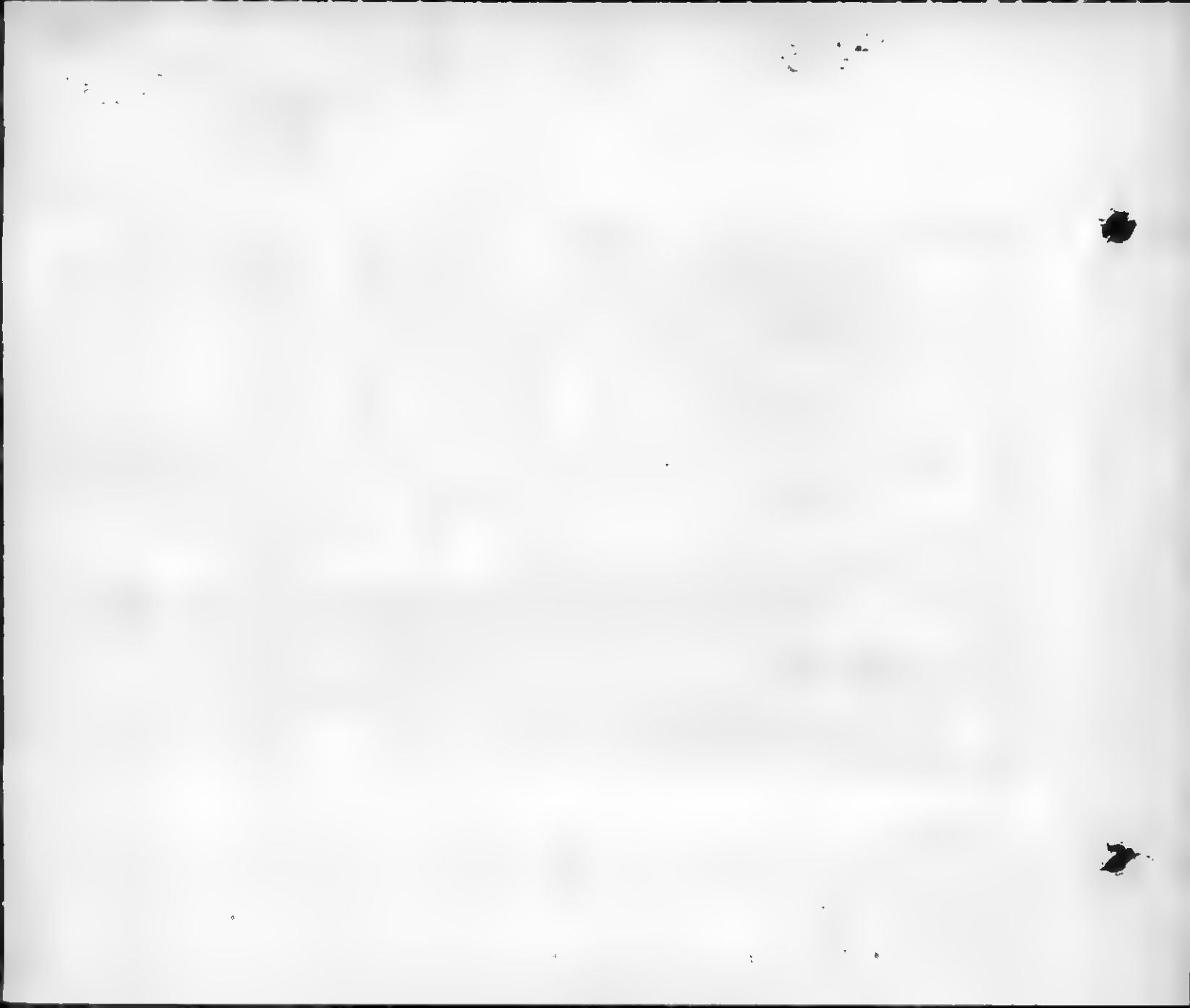
VS AIS (4)  
15M 9/55

12718 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1021</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Clarence</u> Last <u>Lockman</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 15-1930</u>
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR: Months <u>0</u> Days <u>05</u> Hours <u>00</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Brownsville, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William T. Bree</u>		14. MOTHER'S MAIDEN NAME <u>Sara L. Goudy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Sara Jane Wilson</u>		Address <u>1021</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> <u>445X</u> DUE TO <u>Thrombosis Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-10</u> 19 <u>57</u> , to <u>Nov. 5</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 24</u> 19 <u>58</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u> DATE SIGNED <u>11-5-58</u>			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.		PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Brownsville, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Carthen</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12719

## CERTIFICATE OF DEATH

12711

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>184</u> days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. STREET ADDRESS <u>3924 Boarman Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Herbert</u> Last <u>Levin</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 27, 1937</u>
9 AGE (In years last birthday) <u>21</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student (None)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Levin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Silver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>216-34-5790</u>	
17 INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of right foot &amp; pulmonary metastases</u> <u>179.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19</u> <u>1958</u> , to <u>November 19</u> <u>1958</u> , that I last saw the deceased alive on <u>November 19</u> <u>1958</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>James M. Marsh</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/20/58</u>	
PHYSICIAN'S NAME (Type) <u>James M. Marsh, M.D.</u>		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sharon T. Long</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levman &amp; Bros Inc</u>		24a. REC'D BY REGISTRAR <u>1/24/58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12720

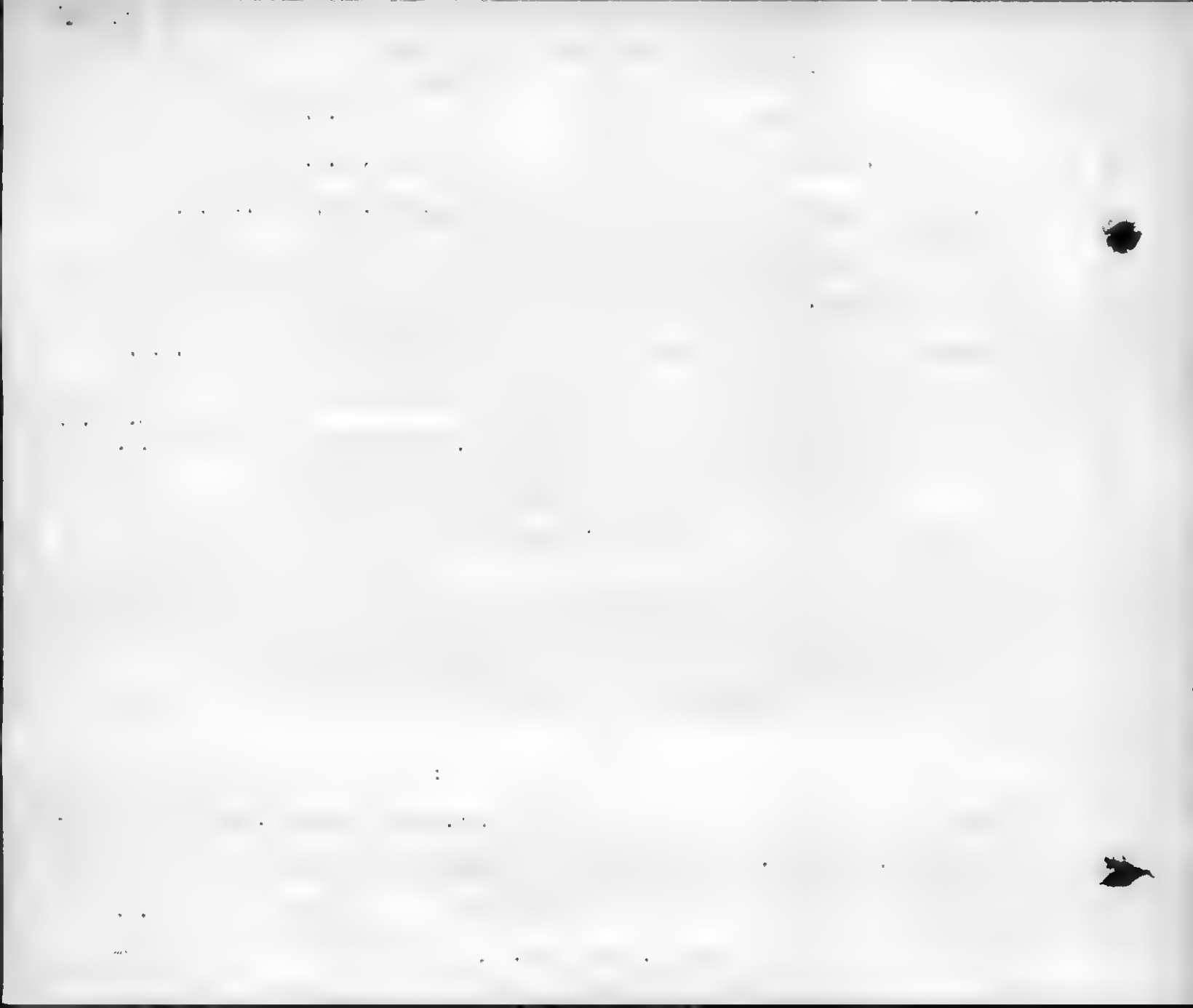
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>		c. LENGTH OF STAY IN 1b <b>25 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>3801 Conn. Ave. NW, Wash., D.C.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>(n)</b> Last <b>LEVINTOHL</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 March 1889</b>		9. AGE (in years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hoyman LEVINTOHL</b>				14. MOTHER'S MAIDEN NAME <b>Jenny STESER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW I 598-246030</b>		17. INFORMANT <b>3020 Rodman St., N.W., Washington, D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Bronchogenic Carcinoma</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>25 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 29, 1958</b> to <b>November 22, 1958</b> that I last saw the deceased alive on <b>November 22, 1958</b> and that death occurred at <b>4:05 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>11-22-58</b> ACTUAL SIGNATURE <i>A. Miale Jr.</i> PHYSICIAN'S NAME (Type) <b>A. MIALE Jr., LT, MC, USN</b> <b>Bethesda, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-23-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Adas Isreal Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. Danzanski</i> <b>Danzanski &amp; Sons, 3501 14th St., NW, Wash., D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 26 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12614

### CERTIFICATE OF DEATH

12713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASH. SAN AND HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
f. STREET ADDRESS <u>115 CROYDON COURT</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH JACKSON LILLIBRIDGE</u>				4. DATE OF DEATH Month Day Year <u>Nov 2 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 16, 1896</u>	9. AGE (In years last birthday) <u>62 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>		11. BIRTHPLACE (State or foreign country) <u>TOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES LILLIBRIDGE</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. LILLIBRIDGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>SPANISH-AMERICAN</u>		17. INFORMANT <u>Mrs. Sarah B. Lillibridge, 115 Croydon Ct.</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial infarction, etc.</u> DUE TO (c) <u>Coronary occlusion.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary atherosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>3-4 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>Nov. 2, 1958</u> , that I last saw the deceased alive on <u>Nov. 2, 1958</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Roberts</u>				DATE SIGNED <u>Nov. 2, 1958</u>			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				ADDRESS (Street, city or town, state) <u>SILVER SPRING, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>11/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MUSCATINE, IOWA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12721 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>1805 37th St., N. W.</b> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>BELLE</b> Last <b>LINDSAY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1873</b>
9. AGE (In years last birthday) <b>85</b>		IF UNDER 1 YEAR: Months <b>1</b> Days <b>8</b> Hours <b>15</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>school teacher (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lewis F. Lindsay</b>		14. MOTHER'S MAIDEN NAME <b>Mary H. Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Kathryn H. Rawls, 1805 37th St., NW</b>		Address <b>Wash., D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerosis - myocardial infarction - indeterminate</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the Colon &amp; Metastases</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August</b> , 19 <b>18</b> , to <b>Nov 8</b> , 19 <b>18</b> , that I last saw the deceased alive on <b>Oct 29</b> , 19 <b>18</b> , and that death occurred at <b>4:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew G. Brandon</b>		M.D. <b>1150 Conn. Ave. N.W. Wash. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Andrew G. Brandon</b>		<b>1150 Conn. Ave. N.W. Wash. D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>11-12-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Waukegan, Illinois</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Rawles Sons, Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



12722

## CERTIFICATE OF DEATH

12715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3159 Tennyson N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Christy</u> Last <u>Lipp</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing-Heating</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Carroll's Lipp</u>				14. MOTHER'S MAIDEN NAME <u>P</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1917</u>		16. SOCIAL SECURITY NO. <u>577-48-2837</u>		17. INFORMANT <u>Carl Lipp Jr.</u> Address <u>Backwood Trail, 5906 Connelley Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POSTERIOR MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis, Posterior Coronary Artery</u> DUE TO (c) <u>Coronary atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 29, 1958</u> to <u>Nov 17, 1958</u> that I last saw the deceased alive on <u>Nov. 17, 1958</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u> M.D.				ADDRESS (Street, city or town, state) <u>5516 Neb. Ave - DC 11-18-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell MD.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Jones Co.</u> ADDRESS <u>2901 14th St NW</u>				24a. REC'D BY REGISTRAR <u>Nov 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thura</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12723 Item 21 1014 12-4-58 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

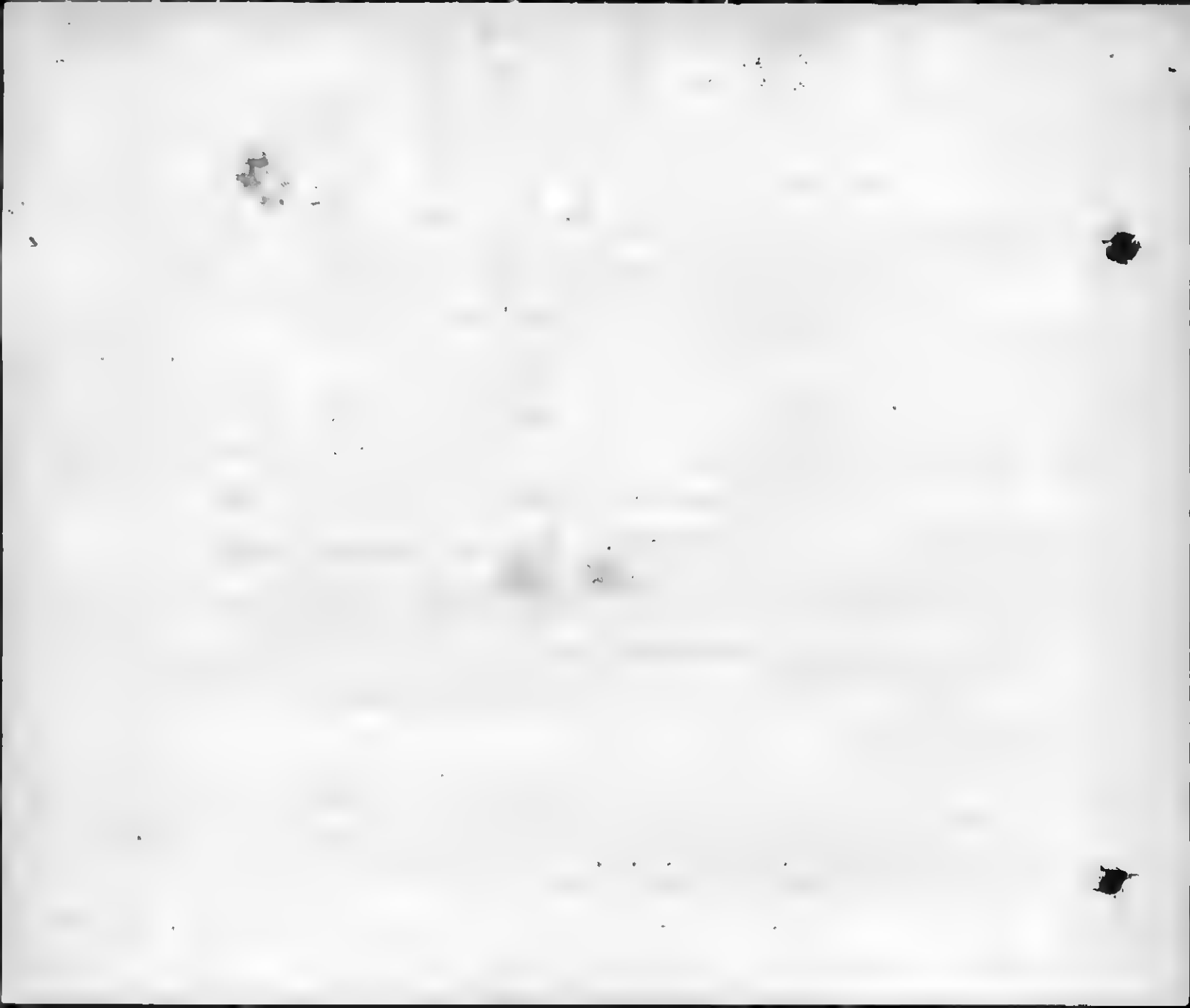
CERTIFICATE OF DEATH

12716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>85 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point of Rocks</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Viola</u> Last <u>Lowery</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1923</u>
9. AGE (In years last birthday) <u>35 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Quincy T. Lowery</u>		14. MOTHER'S MAIDEN NAME <u>Lena Stella Dean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unavailable</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Respiratory failure due to Carcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b). <u>Primary ca. of lung and/or secondary metastatic carcinoma of lung</u> DUE TO (c). <u>Epidermoid carcinoma of cervix uteri</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>171 X</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 27, 1958</u> to <u>November 21, 1958</u> , that I last saw the deceased alive on <u>November 21, 1958</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above <u>6:00</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>11/21/58</u>			
ACTUAL SIGNATURE <u>Marvin M. Ronsdahl, M. D.</u>		The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11/25, 1958</u>	<u>St. Pauls Episcopal</u>	<u>Point of Rocks, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Fill in please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12724

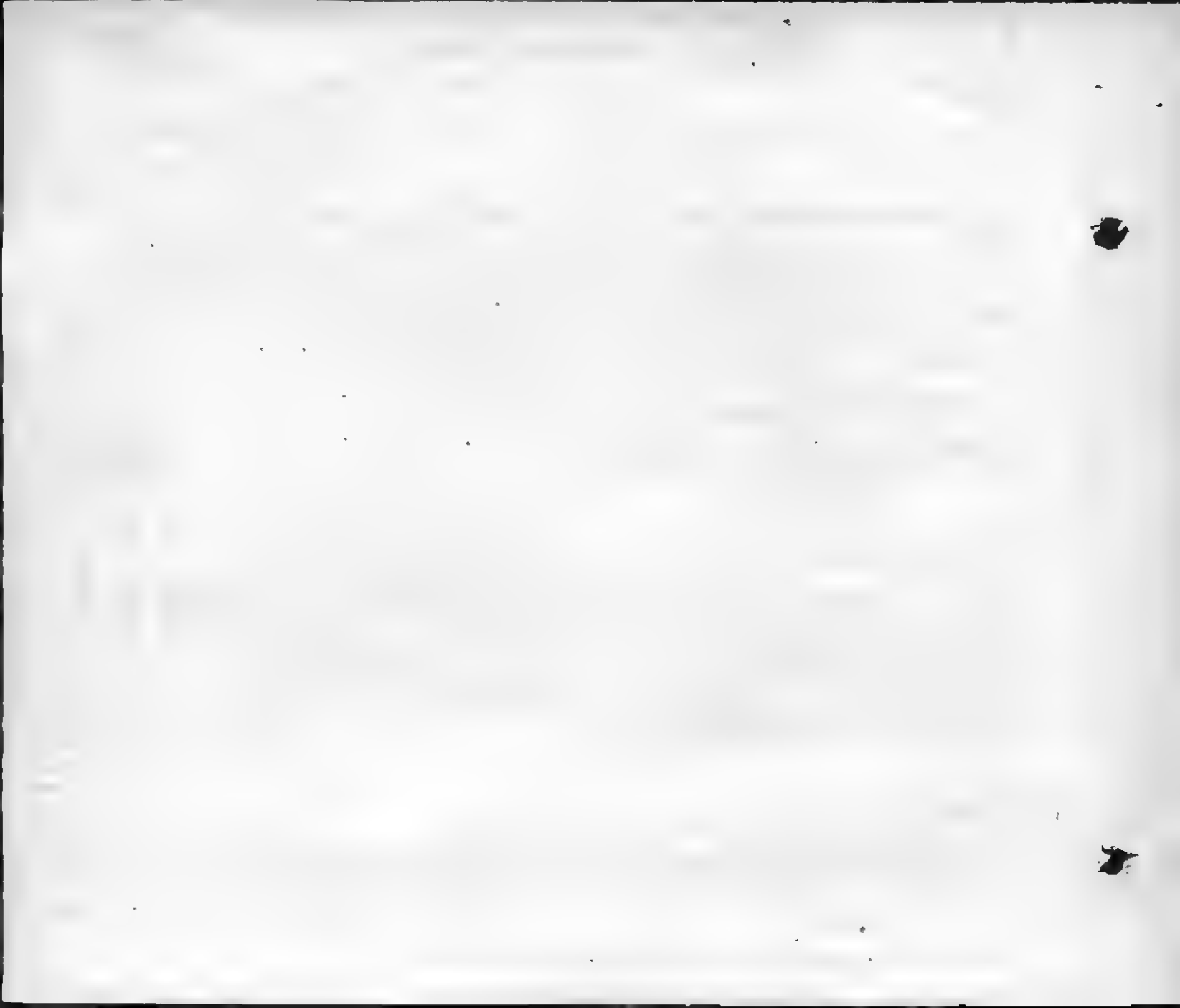
## CERTIFICATE OF DEATH

12717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6820 Delaware Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MORTIMER</b> Middle <b>C</b> Last <b>LYDDANE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 58</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1883</b>		9. AGE (In years last birthday) yrs. <b>74</b>	10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>19</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Thomas O Lyddane</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Sceior</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Clara T. Lyddane-wife-same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute myocardial infarction</b> DUE TO (c) <b>coronary artery disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>70 mins.</b> <b>10-20 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left lower lobe pneumonia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <b>Nov.</b> Day <b>21</b> Year <b>19 58</b> Hour <b>8 P.</b> a. m. <b></b> p. m. <b></b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 21, 19 58</b> , to <b>Nov. 21, 19 58</b> , that I last saw the deceased alive on <b>Nov. 21, 19 58</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sanford J. Randall</b> M.D. <b>3636 16 ST. N.W. D.C.</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>SANFORD T. RANDALL M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 26 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

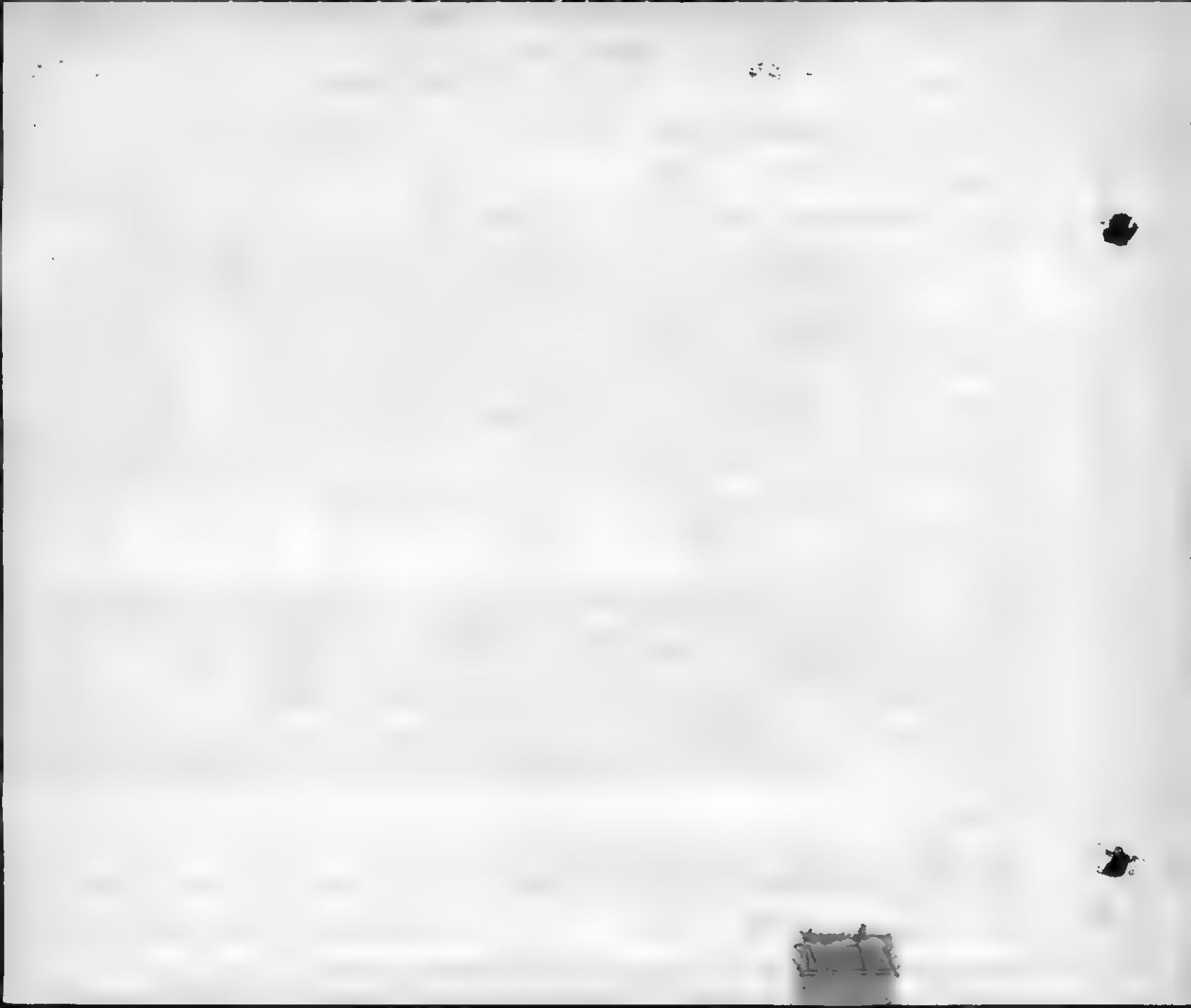


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 12725  
 CERTIFICATE OF DEATH

12718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Marshall</u> Middle <u>MAGRUDER</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 30, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Walter Marion Magruder</u>		14. MOTHER'S MAIDEN NAME <u>Clara Avalon Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-34-5144</u>	
17. INFORMANT <u>Mrs Daisy Magruder</u> Address <u>Brookeville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO (b) <u>Generalized Lympho sarcoma</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Urinary Tract Infection</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 24</u> , 1958, to <u>Nov.</u> , 1958, that I last saw the deceased alive on <u>Nov 24</u> , 1958, and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D. <u>Olney, Md.</u>		DATE SIGNED <u>11-25-58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD A. YATES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 28, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FOREST OAK</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W. BARBER</u> ADDRESS <u>M D Gaithersburg</u>		24a. REC'D BY REGISTRAR <u>C. J. S. S.</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>DEC 1 1958</u>	



12726

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>205 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Phillipsburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phillipsburg</b> d. STREET ADDRESS <b>138 Summit Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patricia Ann Markus</b>		4. DATE OF DEATH Month Day Year <b>November 12, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 18, 1931</b>
9. AGE (In years last birthday) <b>23 yrs</b>		10. IF UNDER 1 YEAR Months Days <b>11 24</b>	11. IF UNDER 24 HRS Hours Min <b>24</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert E. Manners</b>		14. MOTHER'S MAIDEN NAME <b>Verna Bender</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> <b>173X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Bronchiopneumonia</b> DUE TO (c) <b>Malignant Chorion carcinoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>7 days</b> <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>173X</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>12:55 AM</b>
20f. (City or town) <b>12:55 AM</b>		(County) (State)	
21. I certify that I attended the deceased from <b>April 21, 1958</b> , to <b>November 12, 1958</b> , that I last saw the deceased alive on <b>November 12, 1958</b> , and that death occurred at <b>12:55 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 11-12-58</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Donald A. Kellogg</b> M.D.		SIGNATURE <b>Robert A. Pumphrey</b>	
PHYSICIAN'S NAME (Type) <b>Donald A. Kellogg, M. D.</b>		ADDRESS <b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Trans</b>		22b. DATE THEREOF <b>11/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Northampton Mem. Shrine</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>NOV 13 '58</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12727

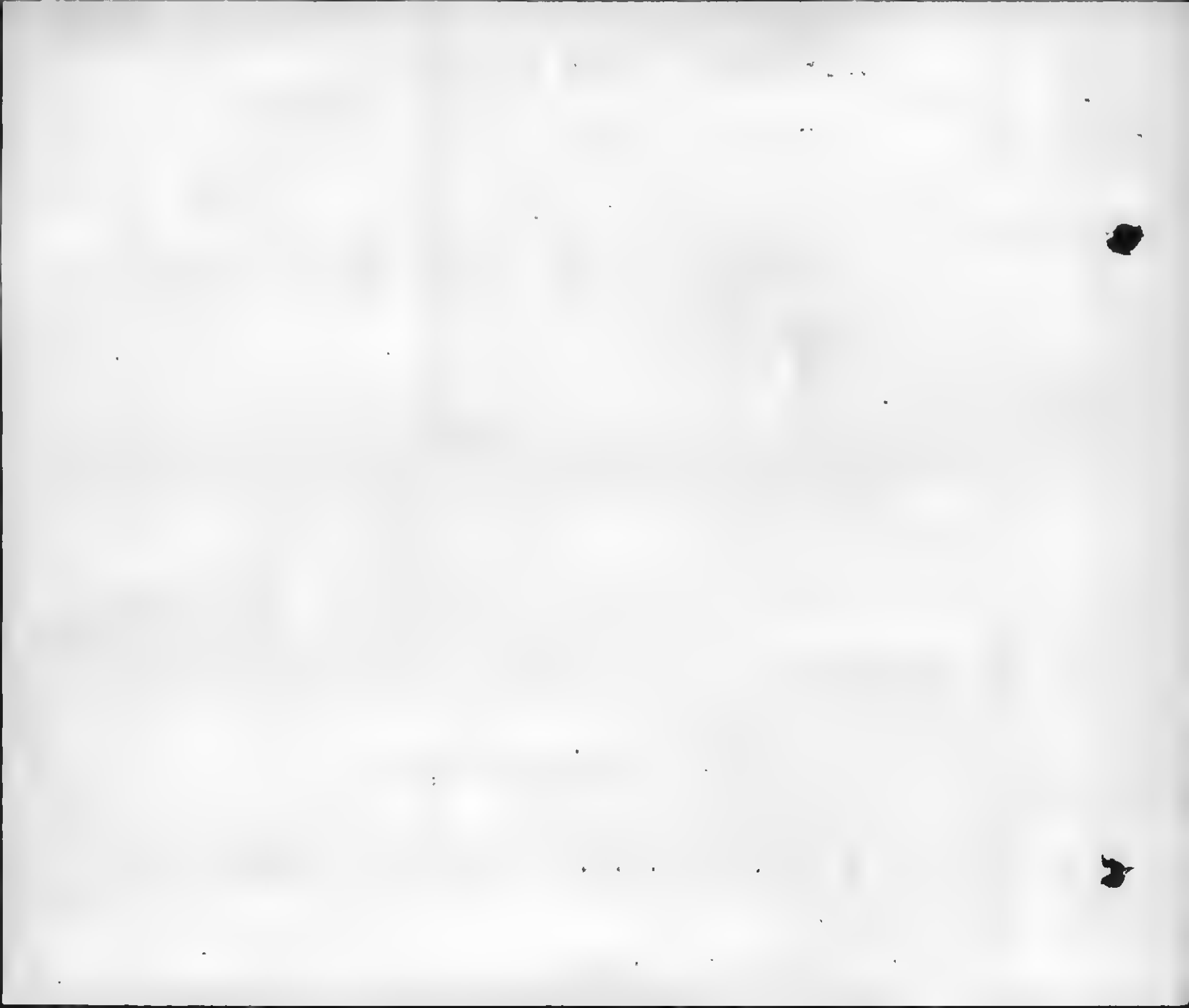
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bauxite</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>Box 426</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anette</u> Middle <u>(none)</u> Last <u>McClain</u>			4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1951</u>		9. AGE (In years last birthday) <u>7</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>James W. McClain</u>				14. MOTHER'S MAIDEN NAME <u>Juanita Orender</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right ventricular heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary hypertension</u> DUE TO (c) <u>Ventricular septal defect, Atrial septal defect</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 2, 1958</u> to <u>November 12, 1958</u> , that I last saw the deceased alive on <u>November 12, 1958</u> , and that death occurred at <u>10:26 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>William P. Cornell</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/13/58</u>			
PHYSICIAN'S NAME (Type) <u>William P. Cornell, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Benton, Arkansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur B. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 18&21 Film 235 11-21-58  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>4308 Ambler Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Naomi A. McIlroy</u>		4. DATE OF DEATH Month Day Year <u>Nov. 4 19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/76</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min <u>82</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Gustafson</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Kern</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>140</u>	
17. INFORMANT <u>John W. McIlroy</u>		Address <u>4308 Ambler Dr. Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive subarachnoid hemorrhage</u>		<u>5 hrs.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Old subdural hemorrhage</u>	
(c) <u>DUE TO</u>		<u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell from roof. head</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4</u> <u>11-4 1958</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Roof</u>	20f. (City or town) (County) (State) <u>Bethesda Montgomery Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>11-4-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>	22d. LOCATION (City, town, or county) (State) <u>Huntingdon, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>John L. Hines</u>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12729 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN TB <u>5 yrs</u>		d. STREET ADDRESS <u>7809 Stratford Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7809 Stratford Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Oscar</u>		4. DATE OF DEATH <u>Nov 26 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1884</u>
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR: Months <u>7</u> Days <u>26</u> IF UNDER 24 HRS: Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>roofing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Charles Mc Intosh</u>		14. MOTHER'S MAIDEN NAME <u>Anna Moulden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1041 B. Sears</u>	
17. INFORMANT <u>Sam as John</u>		Address <u>Sam as John</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (b) <u>subleu</u>			
(c) <u>subleu</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>subleu</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>(Signature)</u>	

DATE SIGNED

11-26-58



12730

## CERTIFICATE OF DEATH

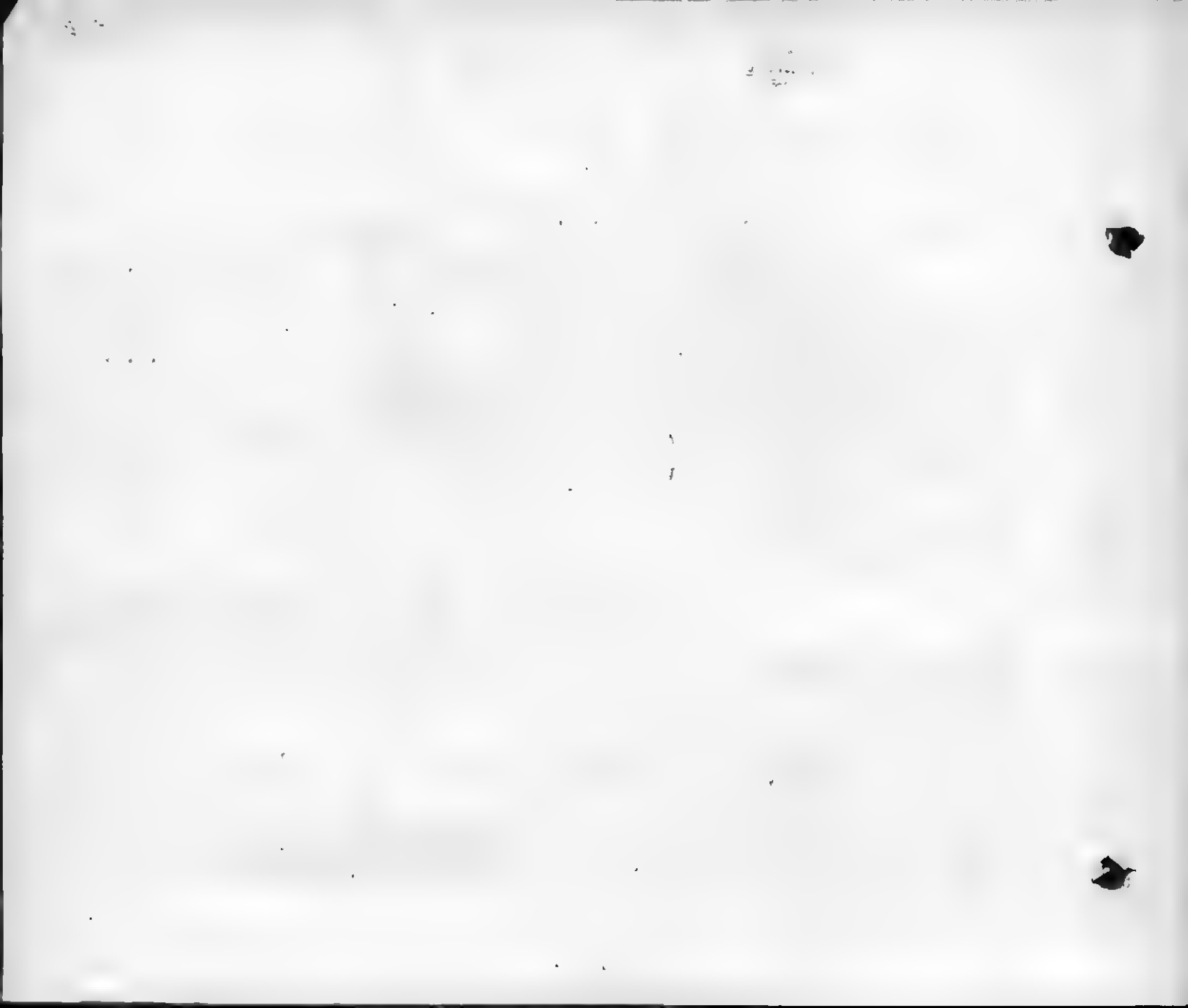
12723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>407 James Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Lady</b> Middle <b>Vera</b> Last <b>McInturff</b>		4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1904</b>
9. AGE (In years last birthday) <b>54 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Wright</b>		14. MOTHER'S MAIDEN NAME <b>Grace Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bleeding gastric ulcers,</b> DUE TO <b>Acute myelogenous leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 yr.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 12, 1957</b> to <b>November 26, 1958</b> , that I last saw the deceased alive on <b>November 26, 1958</b> , and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>11-26-58</b>	
ACTUAL SIGNATURE <b>Harold R. Silberman</b> M.D.		National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) <b>Harold R. Silberman, M.D.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/1/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Beverly Mountcastle</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 1 1958</b>	
Cunningham Funeral Home Alexandria, Va.		24b. REGISTRAR'S SIGNATURE <b>Robert L. Fink</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A13 (4)  
15M 9/55

12615 Maryland State Department of Health - BALTIMORE, 18  
11-17-58 et  
CERTIFICATE OF DEATH

12724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Wood</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakona Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkersburg, West Virginia</u>			
c. LENGTH OF STAY IN 1b <u>1 week</u>				d. STREET ADDRESS <u>1400 7th Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>517 Albany Avenue</u> OR INSTITUTION <u>Conv. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MATTIE FRANCIS MEAD</u>				4. DATE OF DEATH <u>November 7, 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 31, 1867</u>	
9. AGE (In years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery Business (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James Shingleton</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Miss Mildred Gregg, 9922 4th Ave. S.E. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>170X</u> DUE TO <u>Intestinal obstruction partial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholecystitis</u> (c) <u>Tumor of the L breast</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>170X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>11/19/58</u> to <u>11/7/58</u> , that I last saw the deceased alive on <u>11/6/58</u> , and that death occurred at <u>500 Underwood St NW</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. H. Wolcott</u> M.D.				DATE SIGNED <u>Washington DC</u>			
PHYSICIAN'S NAME (Type) <u>Chas. H. Wolcott</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkersburg, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. D. Walter</u> ADDRESS <u>254 Carroll Rd NW</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

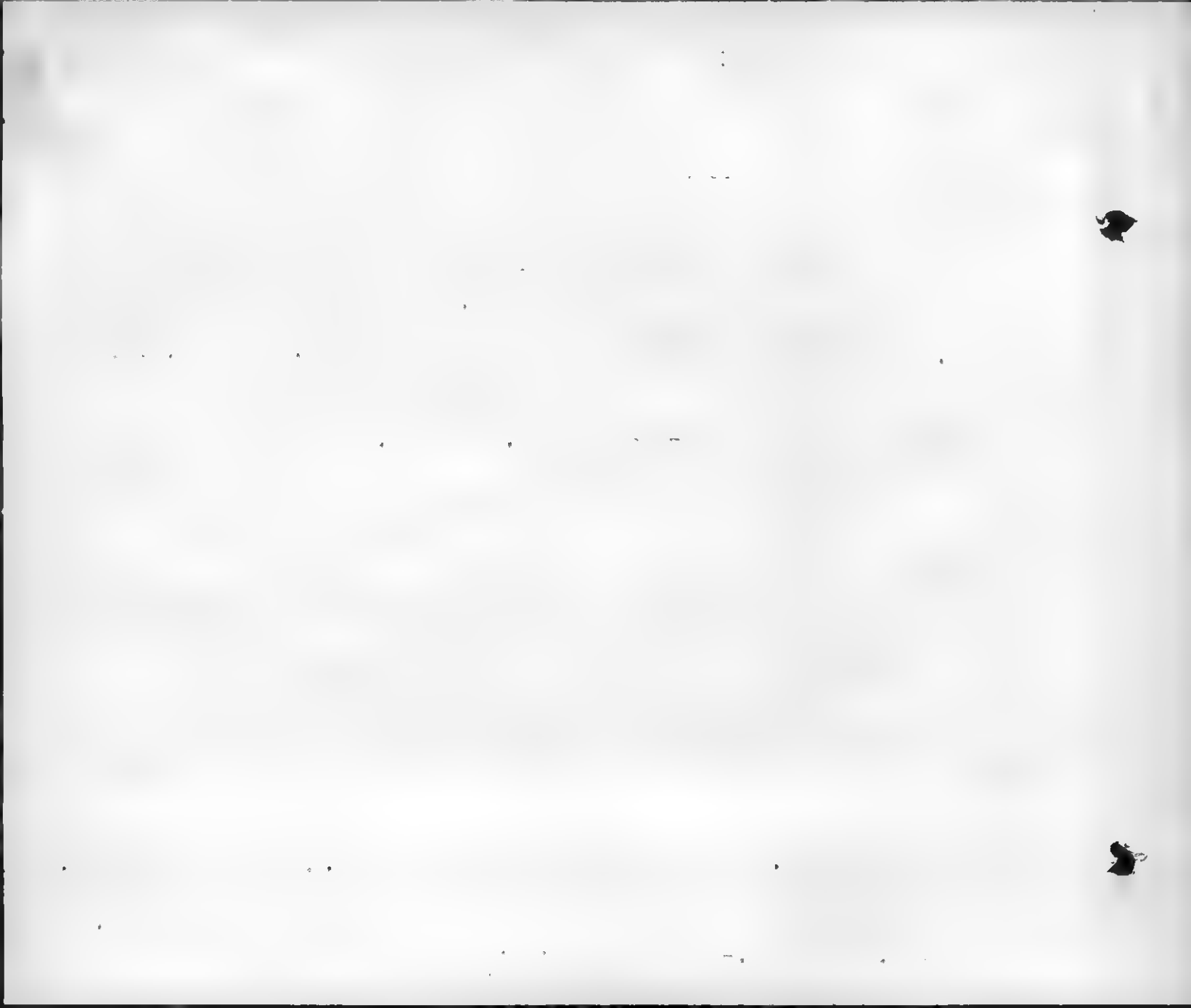
12731

## CERTIFICATE OF DEATH

Reg. Dist. No. 12725

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville, Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 Midland Road</b>		d. STREET ADDRESS <b>607 Midland Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Eugene Mercogliano</b>		4. DATE OF DEATH Month Day Year <b>November 30, 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1920</b>
9. AGE (In years last birthday) <b>38 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ass't. Chief Technical Program</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Internal Revenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Angelo Mercogliano</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Ricci</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>yes (Coast Guard)</b>		16. SOCIAL SECURITY NO. <b>579-09-1331</b>	
17. INFORMANT <b>Mrs. Carol J. Mercogliano - Same #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>148X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Retropharyngeal Carcinoma.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Staphylococcus Septicemia (healed)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1958</b> to <b>30 Nov 1958</b> that I last saw the deceased alive on <b>29 Nov 1958</b> and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Thomas P. Fogarty, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Thomas P. Fogarty -- 1036 University Blyde Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. - 2901 14th St., N.W.</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>	
ADDRESS <b>Washington 9, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. P. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12732

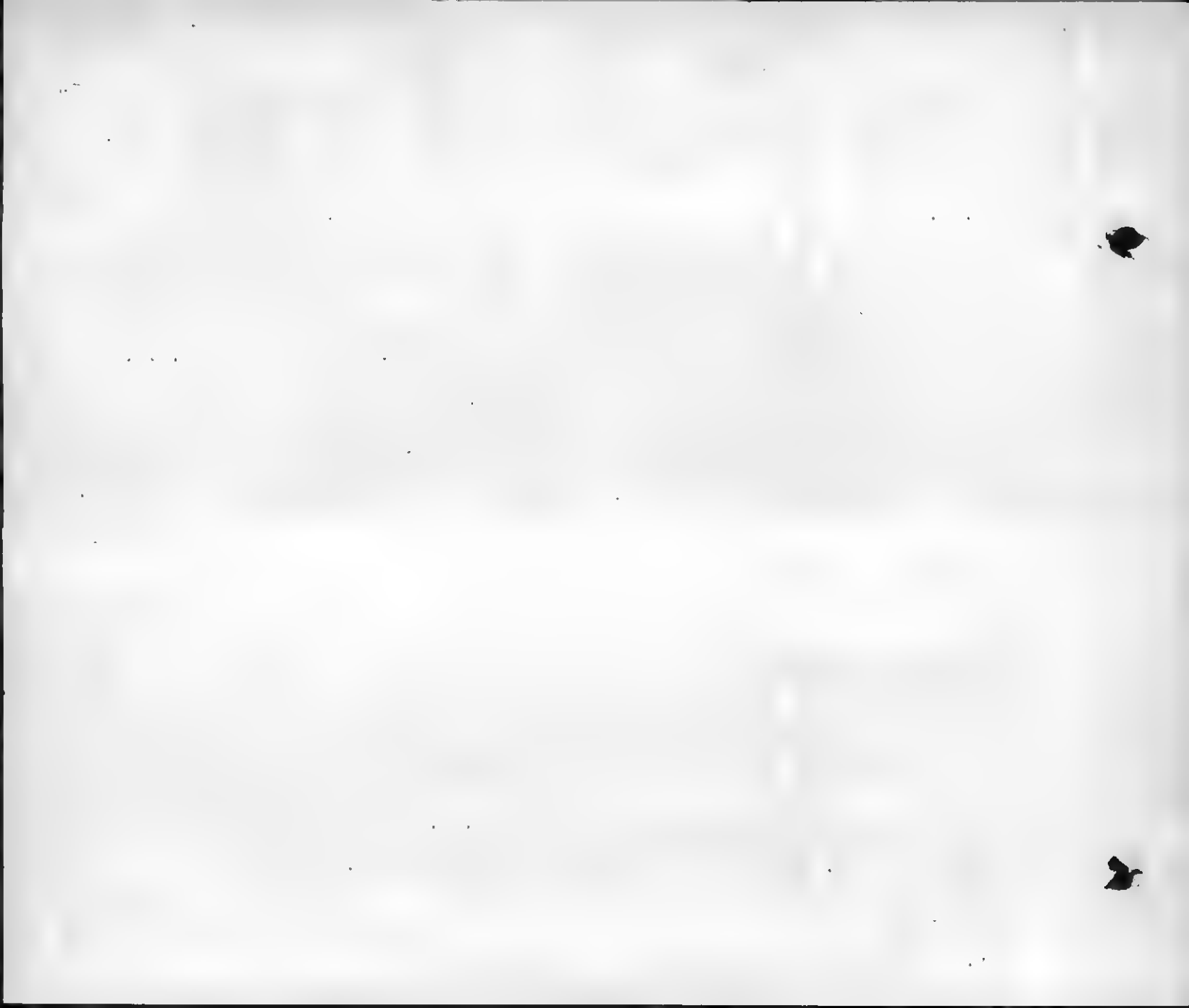
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 hrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>5615 McKinley Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carel Hasson MILLER</b>		4. DATE DEATH Month Day Year <b>November 25 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-99</b>
9. AGE (In years last birthday) <b>59 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John HASSON</b>		14. MOTHER'S MAIDEN NAME <b>Josephine NORLING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>(II) Francis G. Miller, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction, myocardium</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Diabetes, mellitus</b> <del>X</del> <b>and (c) Hypothyroidism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>32 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 25, 19 58</b> , to <b>November 25, 19 58</b> , that I last saw the deceased alive on <b>November 25, 19 58</b> , and that death occurred at <b>1:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. M. Young</i>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NMMC</b>	
DATE SIGNED <b>11-25-58</b>			
PHYSICIAN'S NAME (Type) <b>J. M. YOUNG, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Humphrey</i>		ADDRESS <b>Home, 7557 Wisc. Ave., Bethesda</b>	
24a. REC'D BY REGISTRAR <b>NOV 28 '58</b>		24b. REGISTRAR'S SIGNATURE <i>W. S. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 9 of 11-7-58  
 12733  
 CERTIFICATE OF DEATH

12728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>15486 WISCONSIN AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>H</u> Last <u>MILMAN</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 6 1986</u> AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Letter Carrier</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MYER MILMAN</u>				14. MOTHER'S MAIDEN NAME <u>RACHAEL UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>MR Aaron Milman</u> Address <u>4000 Mass Ave Wash D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Coronary failure</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1P</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>58</u> , to <u>11/1</u> , 19 <u>58</u> that I last saw the deceased alive on <u>11/1</u> , 19 <u>58</u> , and that death occurred at <u>3:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Donald P. Elman</u> M.D.							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>Nov. 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. Wangansky &amp; Sons</u> ADDRESS <u>3501-14 St. NW. D.C.</u>				24a. REC'D BY REGISTRAR <u>NOV 5 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



## 12734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13 &amp; 17 Fill in G-236 12/4/58.cac.

Reg. Dist. No.

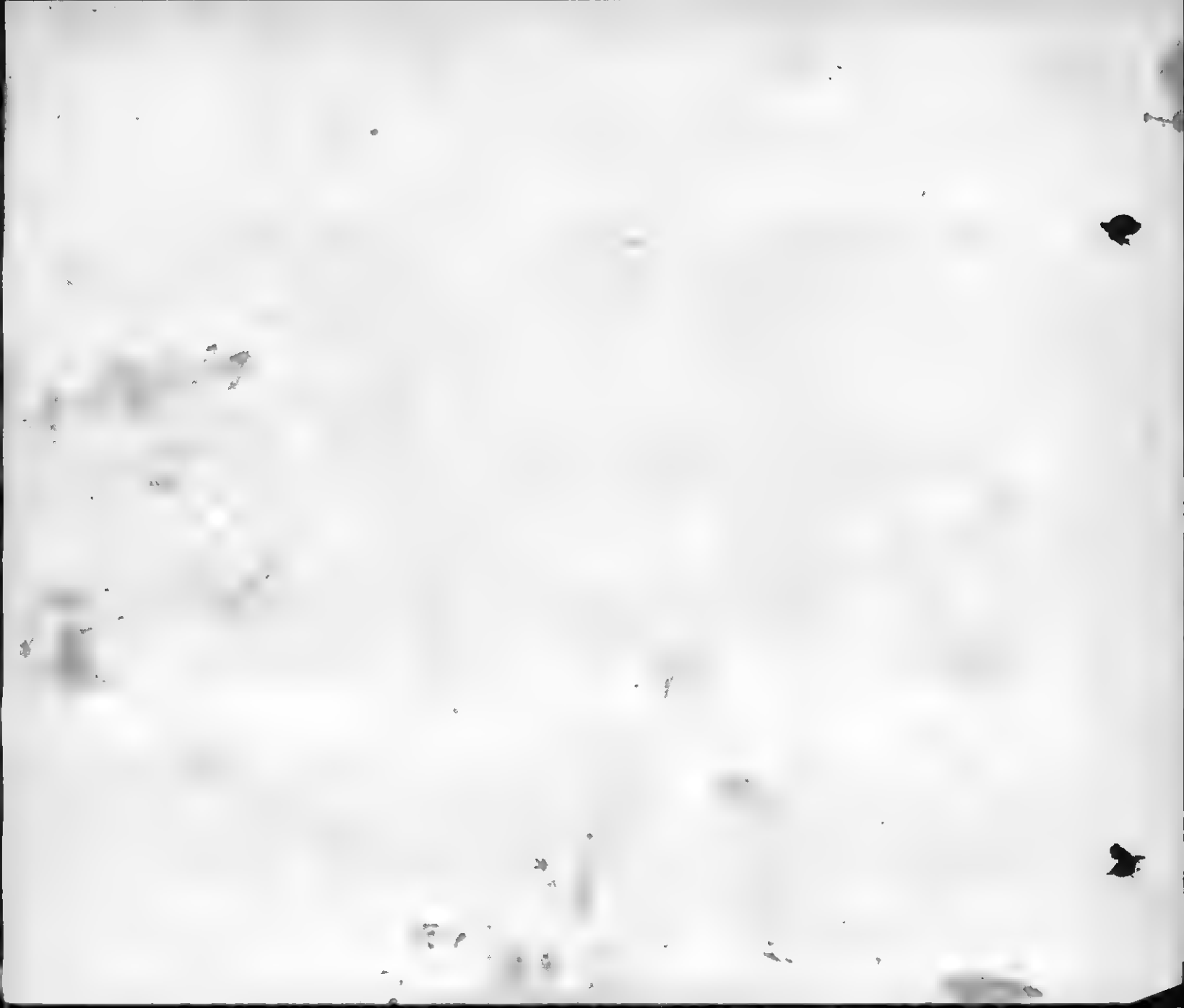
FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst. put on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If out of corporate limits, write R.U.P.A. and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		e. STREET ADDRESS <u>No. R - 124</u>	
3. NAME OF DECEASED (Type or print) <u>Forrest Tuttle Minor</u> MINOR		4. DATE OF DEATH <u>Nov. 15, 1958</u> 19	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1903</u>
9. AGE (in years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elbert Minor</u>		14. MOTHER'S MAIDEN NAME <u>May Breeding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Minor</u> Address: <u>  </u>		18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c)]	
18a. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Tetraethyl Pyrophosphate Poisoning</u>		18b. DUE TO <u>  </u>	
18c. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>		18d. DUE TO <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Taken 4 oz. Kilmit P at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>  </u> 19 <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>  </u>		22d. LOCATION (City, town, or county) <u>  </u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Partner. Gaithersburg Md.</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12616**  
**CERTIFICATE OF DEATH**

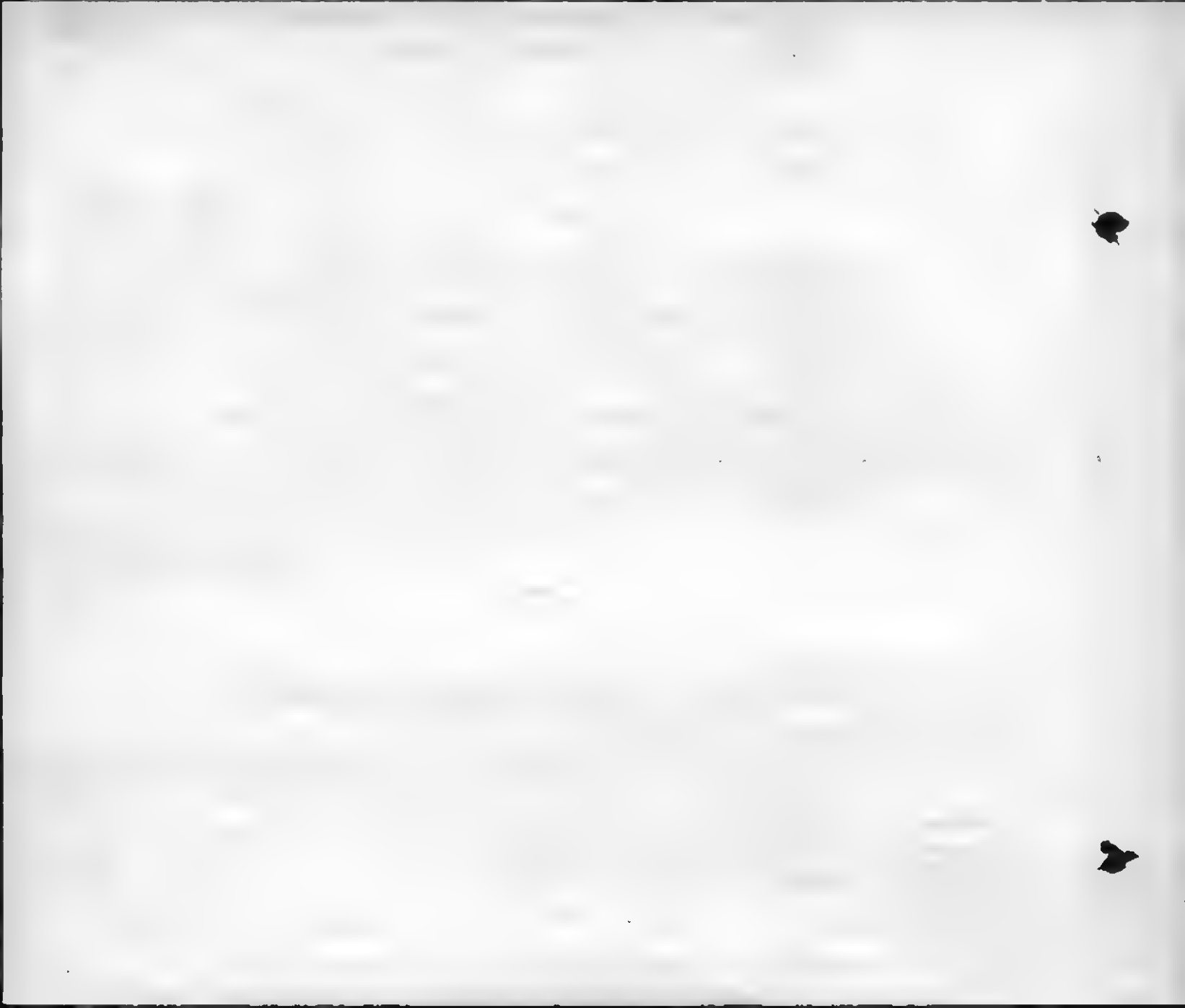
**12730**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN U.S. <u>12 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution, Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>4th</u> d. STREET ADDRESS <u>5939 2nd Street N.W.</u>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>EDITH E. MOORE</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>25</u> Year <u>1958</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 8 1889</u>		<b>9. AGE</b> (In years last birthday) <u>69</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS																
Months	Days																
	Hours																
	Min.																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Wash. D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>							
<b>13. FATHER'S NAME</b> <u>Walter Ridgeway</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Hospital Record</u> Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>Acute Nephritis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u> <u>Indefinite</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>										<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I attended the deceased from</b> <u>Oct. 29, 1958, to Nov. 25, 1958</u> , that I last saw the deceased alive on <u>Nov. 25, 1958</u> , and that death occurred at <u>7:30 P.</u> from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <u>A. B. Little</u> M.D. <u>6911 5th St. N.W.</u> <b>DATE SIGNED</b> <b>PHYSICIAN'S NAME (Type)</b> <u>A. B. LITTLE MD</u> <u>Wash. D.C.</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>11/29/58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Homewood</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Bladensburg Md.</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Fitzhugh Funeral Home</u> ADDRESS <u>510 C St. N.W.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>Nov 29 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Lewis</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 and 4 be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



12735

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>UNKNOWN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNKNOWN</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		d. STREET ADDRESS <u>6302 Hollins Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6302 Hollins Dr.</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Samuel Edward Morthy</u>		4. DATE OF DEATH Nov. 14, 1958	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/1910</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C. "Easton"</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/17/58	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>11-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. S. Md. Med. Schol</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Anderson</u>		ADDRESS <u>  </u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 21 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12736 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12732

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN TB <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Hunter St</u>			f. STREET ADDRESS <u>103 Hunter St</u>		
3. NAME OF DECEASED (Type or print) <u>Moritz Ludwig Mueller</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>29</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-92</u>	9. AGE (in years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Eng.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>
13. FATHER'S NAME <u>Richard Mueller</u>			14. MOTHER'S MAIDEN NAME <u>Katie Walker</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO		
17. INFORMANT <u>Cecilia Mueller (wife)</u>			Address <u>Stim...</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn</u>	
22d. LOCATION (City, town, or county) <u>Bladensburg</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. C. G. Yantow</u>			24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>		
ADDRESS <u>Gaithersburg Md.</u>			24b. REGISTRAR'S SIGNATURE		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



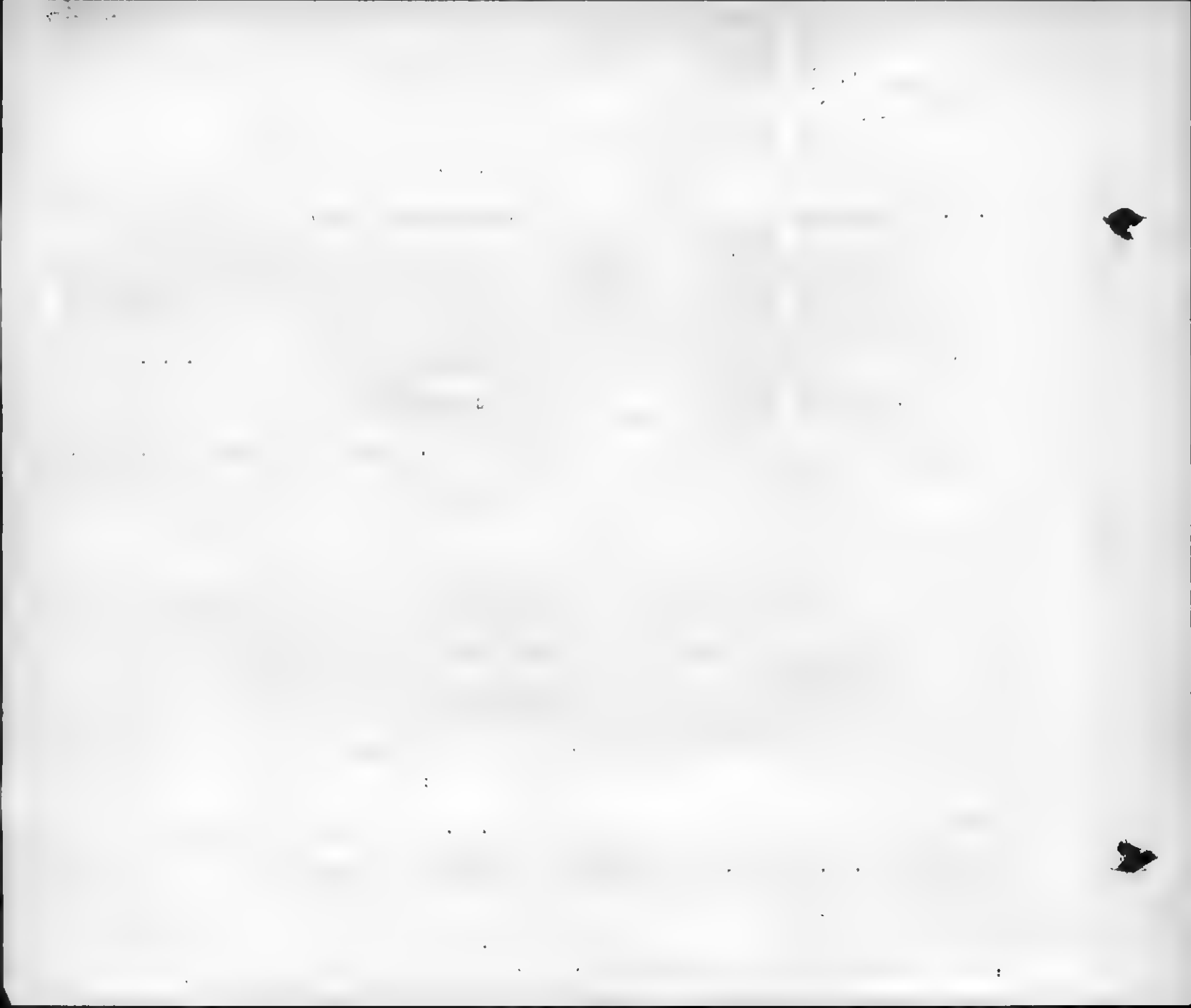
12737

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>124 Anderson Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Blain Allen MUMBY</b>				4. DATE OF DEATH Month Day Year <b>November 4 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-31-58</b>	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours Min. <b>4</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Donald C. MUMBY</b>				14. MOTHER'S MAIDEN NAME <b>Patricia ALLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Md. (F) Donald C. Mumby, 124 Anderson Ct., Lex.Pk.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hyaline membrane disease</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to</b> (c) <b>Due to</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 31, 1958</b> , to <b>November 4, 1958</b> , that I last saw the deceased alive on <b>November 4, 1958</b> , and that death occurred at <b>6:40PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NNMC 11-5-58</b>							
ACTUAL SIGNATURE <b>H. L. Walton</b>				M.D. <b>U. S. Naval Hospital, NNMC</b>			
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN</b>				<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-7-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND DEPARTMENT OF HEALTH-BALTIMORE, 18

12734

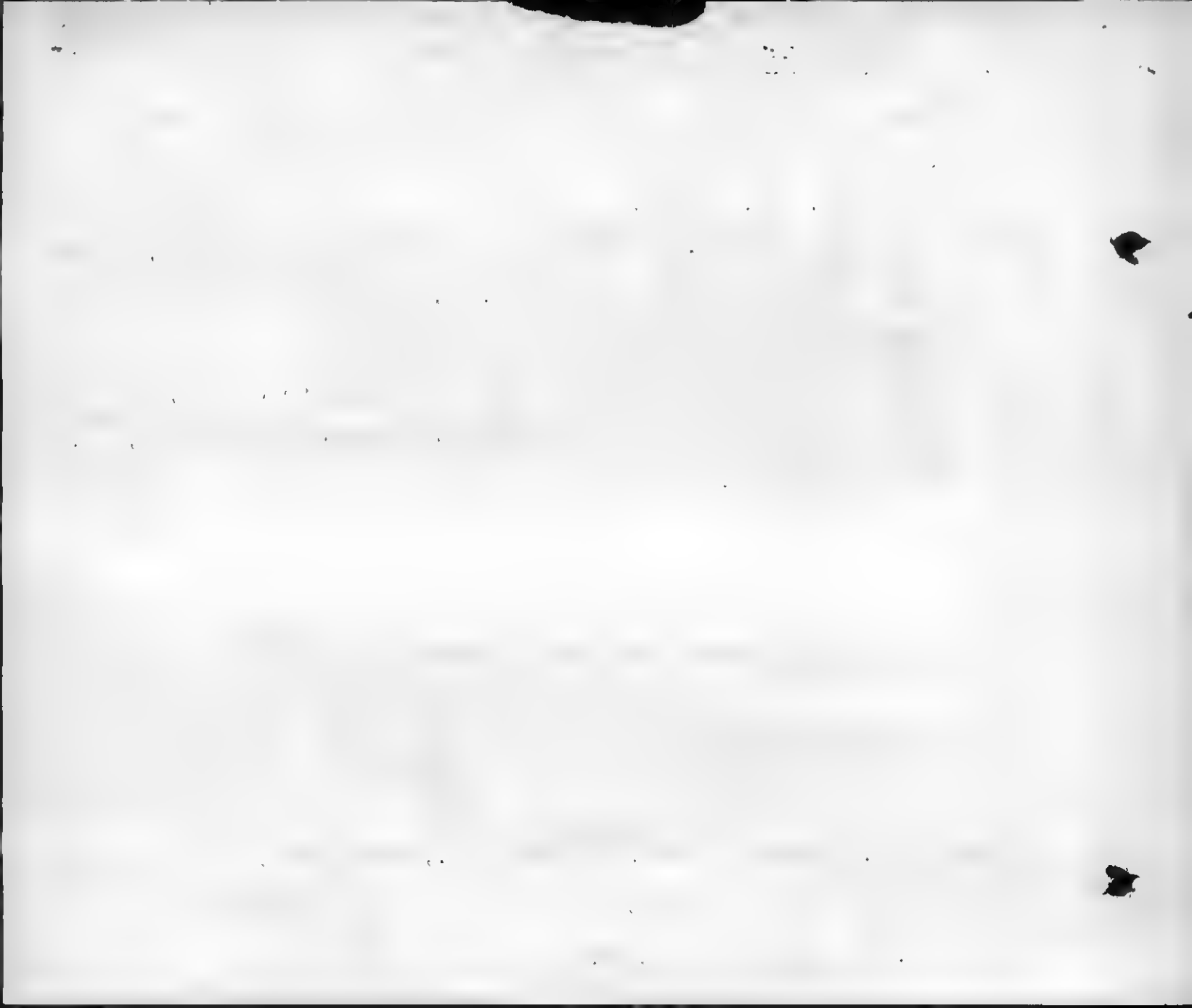
12738

Item 7 FilmG250 12-4-58 EL

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. Gen. Hospital</b>		e. STREET ADDRESS <b>RFD</b>	
3. NAME OF DECEASED (Type or print) <b>EVA</b> First <b>H.</b> Middle <b>NEEL</b> Last		4. DATE OF DEATH <b>November 25,</b> 19 <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs		IF UNDER 1 YEAR <b>3</b> Months <b>10</b> Days	IF UNDER 24 HRS. <b>Hours</b> <b>Min</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Groceries</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Edwin S. Houck</b>	
14. MOTHER'S MAIDEN NAME <b>Susan B. Hammitt</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>579-24-4724</b>		17. INFORMANT <b>Rodney M. Thompson-Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO (b) <b>Pulmonary Edema</b> DUE TO (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Old Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19 <b>11-25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-25</b> , 19 <b>58</b> , and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. I. Leal</b> M.D.		DATE SIGNED <b>11-25-58</b>	
PHYSICIAN'S NAME (Type) <b>L. I. Leal</b>		ADDRESS <b>108 N. Frederick Ave., Gaithersburg, Maryland</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/29/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Neelsville</b>	22d. LOCATION (City, town, or county) (State) <b>Neelsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>NOV 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. ...</b>	



12739

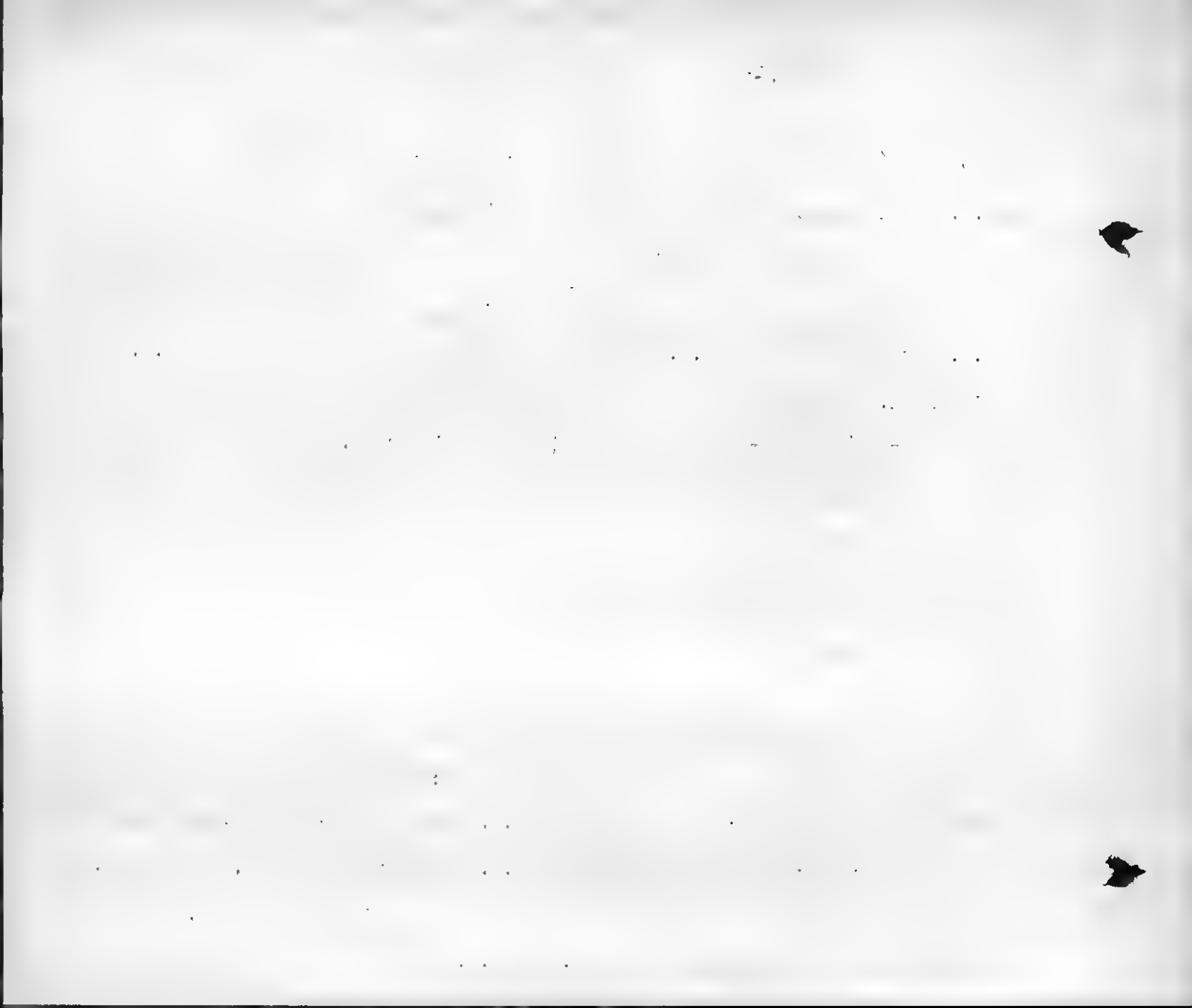
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Minnesota</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>	c. LENGTH OF STAY IN 1b <b>71 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Minneapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>		d. STREET ADDRESS <b>1937 County Road "H"</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leonard Alfred NELSON</b>		4. DATE OF DEATH Month Day Year <b>November 27 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-30-40</b>
9. AGE (In years last birthday) yrs. <b>18</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard T. NELSON</b>		14. MOTHER'S MAIDEN NAME <b>Ester VERHALST</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>743-58 toll-27-58 475 44 3066</b>	
17. INFORMANT Address <b>(Father) Richard T. NELSON (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>glioblastoma multiforme</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>11/21/58</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>26 September, 1958</b> to <b>27 November, 1958</b> , that I last saw the deceased alive on <b>27 November, 1958</b> , and that death occurred at <b>8:40 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Matthew W. Wood MD</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, NNMC, Bethesda Md 11-28-58</b>	
PHYSICIAN'S NAME (Type) <b>Matthew W. WOOD LCDR MC USN</b>		<b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-2-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Minneapolis Minn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Adams Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12740

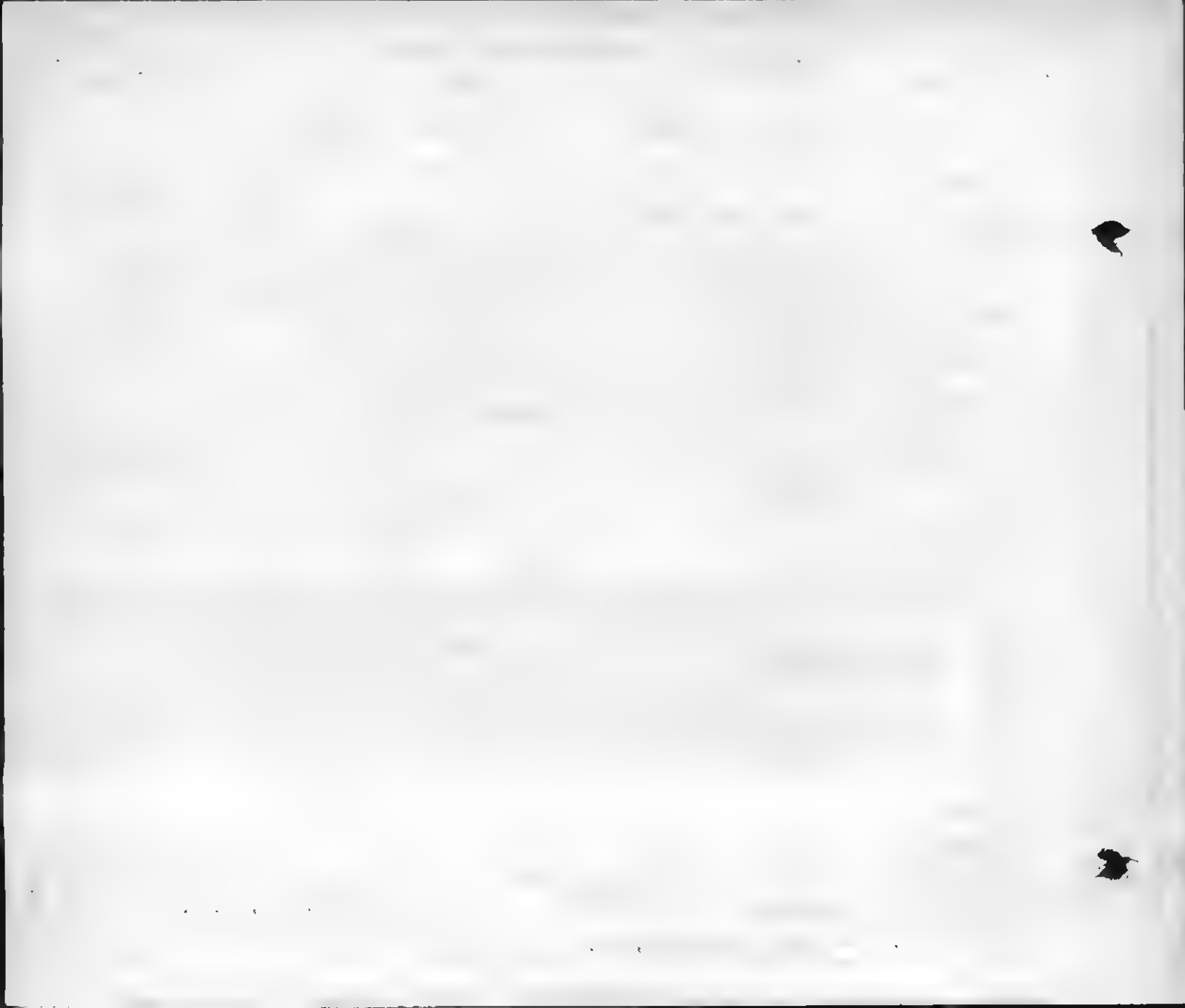
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>3417 Turner Lane</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Margaret A O'Connor</i>				4. DATE OF DEATH Month Day Year <i>Nov 30 1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/25/1904</i>	9. AGE (In years last b. day) <i>54</i> yrs.	IF UNDER 1 YEAR: Months <i>5</i> Days <i>5</i> Hours <i></i> Min. <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Phoenix Arizona</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Albert Sidney Arthur</i>				14. MOTHER'S MAIDEN NAME <i>Ruth Sullivan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>				16. SOCIAL SECURITY NO <i>Unknown</i>			
17. INFORMANT <i>Francis O'Connor (husband)</i>				Address <i>3417 Turner Lane</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Naturalistic Circumstances</i> <i>153.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Circumstances Long Intestine</i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 MONTH</i> <i>6 MONTH</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m p m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1958</i> to <i>Nov 1958</i> , that I last saw the deceased alive on <i>Nov 29 1958</i> , and that death occurred at <i>4:10 A.M.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>1016 GERRYSTOWN RD</i> DATE SIGNED <i>11/30/58</i>							
ACTUAL <i>Leo I O'Connor MD</i> M.D. <i>1016 GERRYSTOWN RD</i>							
PHYSICIAN'S NAME (Type) <i>LEO I O'CONNOR M.D.</i>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/3/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>				24a. REC'D BY REGISTRAR <i>DEC 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Leo I O'Connor</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.



12741

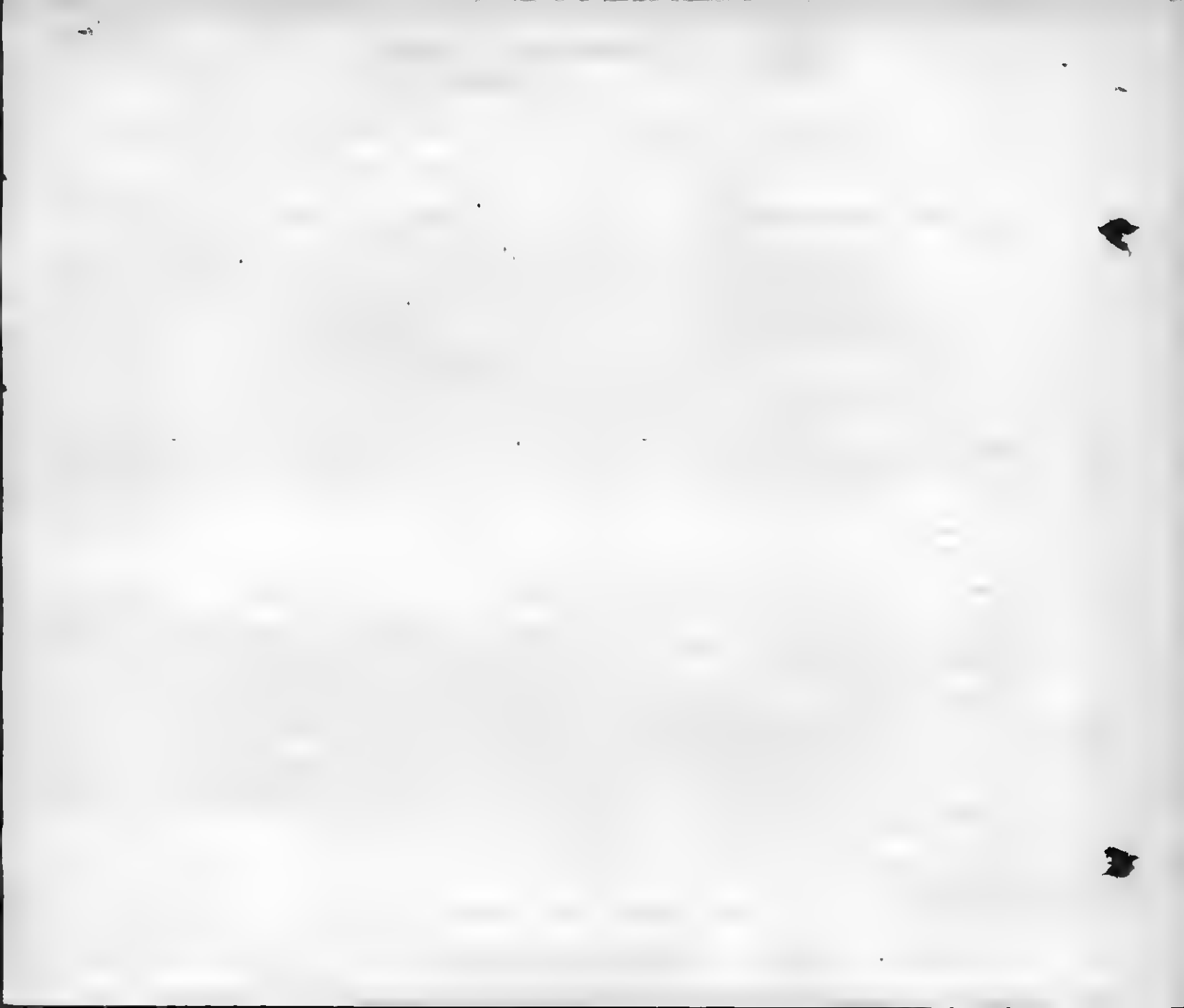
CERTIFICATE OF DEATH

12737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4420 Ridge Street</b>				d. STREET ADDRESS <b>4420 Ridge Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>H</b> Last <b>O'NEAL</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1872</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b>		IF UNDER 24 HRS Hours <b>6</b> Min. <b>15</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hillary O'Neal</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Relay</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-07-5302</b>		17. INFORMANT Address <b>Mrs. Hazel R Howell-daughter-same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line—(a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Arteriosclerotic Heart Disease</b> (c) <b>Coronary Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>8 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>54</b> , to <b>Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 7</b> , 19 <b>58</b> , and that death occurred at <b>6:50</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2016 Georgetown Rd</b> DATE SIGNED <b>11/15/58</b>							
ACTUAL SIGNATURE <b>Leo I Donovan M.D.</b>				PHYSICIAN'S NAME (Type) <b>LEO I DONOVAN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. H. E. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12742

## CERTIFICATE OF DEATH

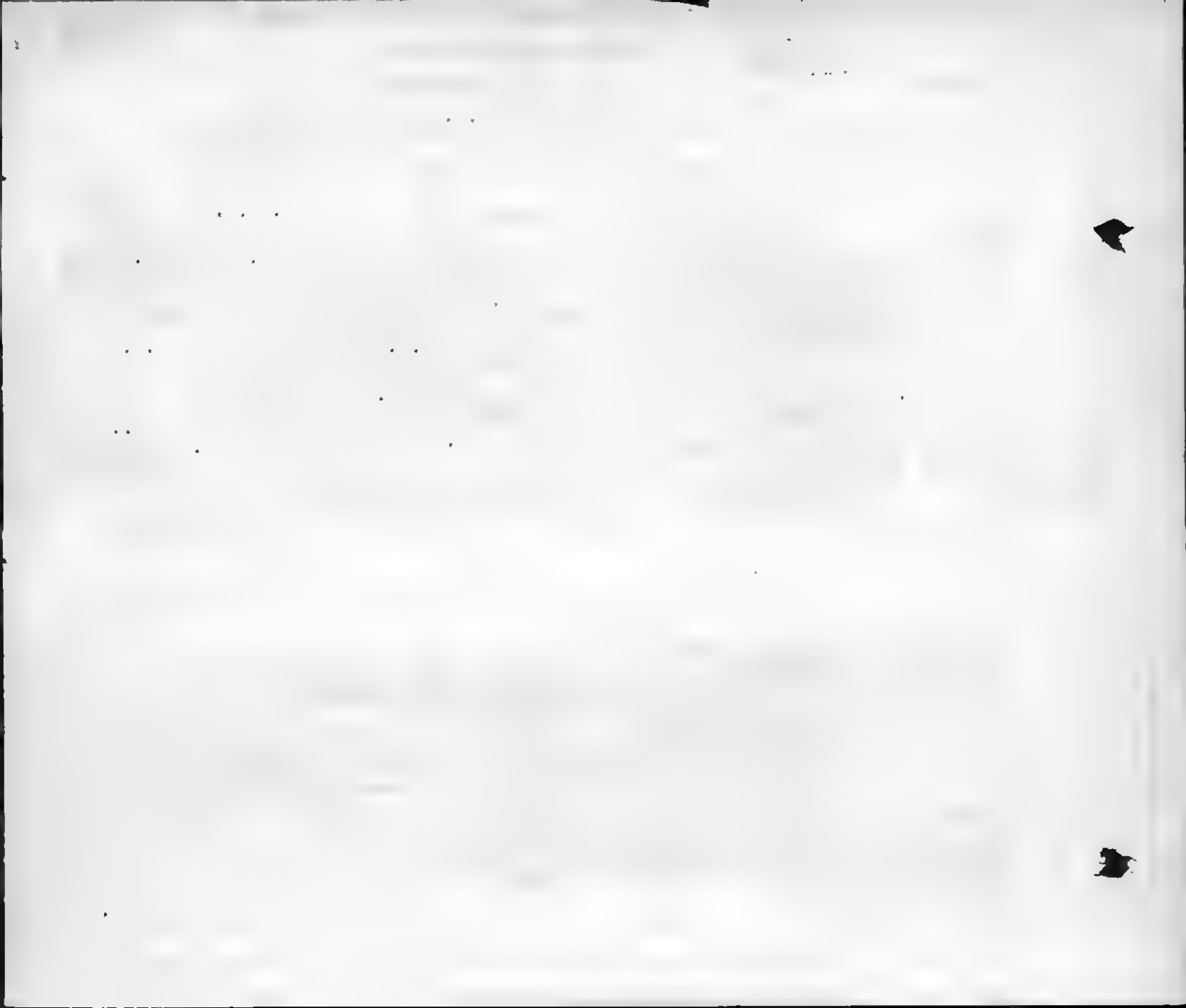
12738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rasmor San. &amp; Hosp.</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year <b>19</b>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>561.4</b> DUE TO <b>Myocardial Infarction</b>							<b>1 1/2</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							<b>1 1/2</b>
(b) <b>Myocardial Infarction</b>							<b>1 1/2</b>
(c) <b>Myocardial Infarction</b>							<b>1 1/2</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-1-58</b> to <b>11-1-58</b> , that I last saw the deceased alive on <b>11-1-58</b> , and that death occurred at <b>11:00</b> PM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Cherry Chase Fund Home</b> M.D. <b>Cherry Chase Fund Home</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Fund Home</b> ADDRESS <b>5703 2nd Ave Wash. D.C.</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <b>NOV 5 '58</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

12743

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2307 FOREST GLEN ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>ERMON</u> Last <u>PARSONS, SR.</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/83</u>
9. AGE (In years last birthday) <u>76 5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Mechanic (retired) Stanley Horner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SEWEL ERNEST PARSONS</u>		14. MOTHER'S MAIDEN NAME <u>MARY HANLIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-20-1908</u>	
17. INFORMANT <u>Mr. Elmer E. Parsons, Jr.</u>		Address <u>2307 Forest Glen Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Hypostatic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Larynx with Metastasis</u> (c) <u>Pulmonary Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 19, 1957</u> to <u>Nov 23, 1958</u> , that I last saw the deceased alive on <u>November 23, 1958</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.; Takoma Park, Md.</u> DATE SIGNED <u>Nov 23, 1958</u>			
ACTUAL SIGNATURE <u>Elmer W. Lorenz, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Elmer W. Lorenz, MD</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Marshall Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marshall, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Raymond A. Zucka</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12744

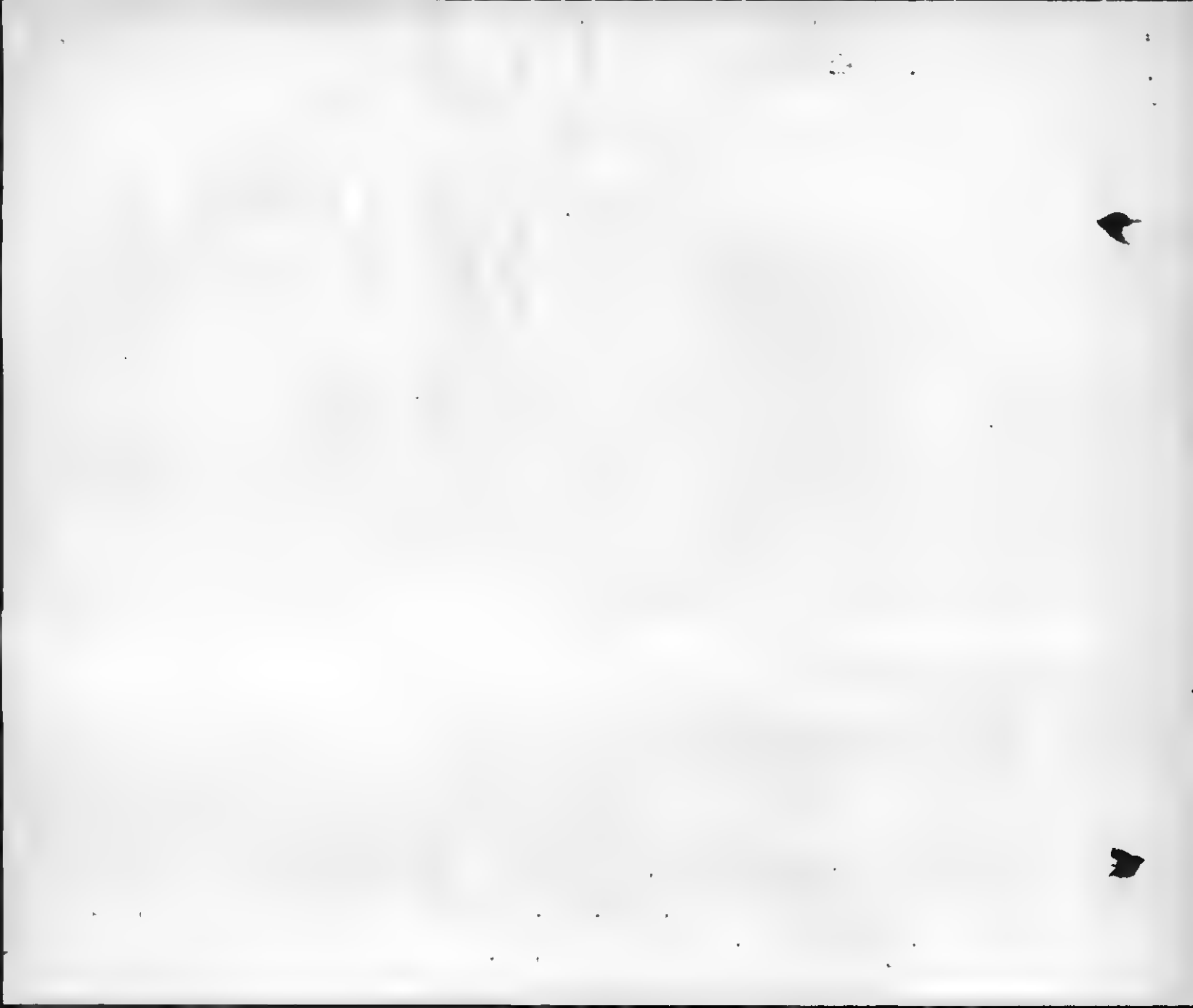
## CERTIFICATE OF DEATH

12740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>14 hours</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park 17</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Count. General Hospital, Inc.</b>						d. STREET ADDRESS <b>8705 Gilbert Place Apt. #3</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Oliver A. Patterson</b>		4. DATE OF DEATH Month Day Year <b>November 28 1958</b>									
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/14/64</b>	9. AGE (In years last birthday) <b>94</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13. FATHER'S NAME <b>William Patterson</b>				14. MOTHER'S MAIDEN NAME <b>Clarissa Harcraft</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Olney, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Insulin Shock</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Prostatic Cancer, Metast.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>261 x</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>1954</b> , to <b>28 Nov</b> , 1958, that I last saw the deceased alive on <b>27 Nov</b> , 1958, and that death occurred at <b>6:20 AM</b> , from the causes and on the date stated above											
ACTUAL SIGNATURE <b>J. B. Ziegler M.D.</b>				ADDRESS (Street, city or town, state) <b>Olney, Md</b>							
DATE SIGNED <b>28 Nov 58</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/1/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GEO. WASH. MEM. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>SEC 1 '58</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12745

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

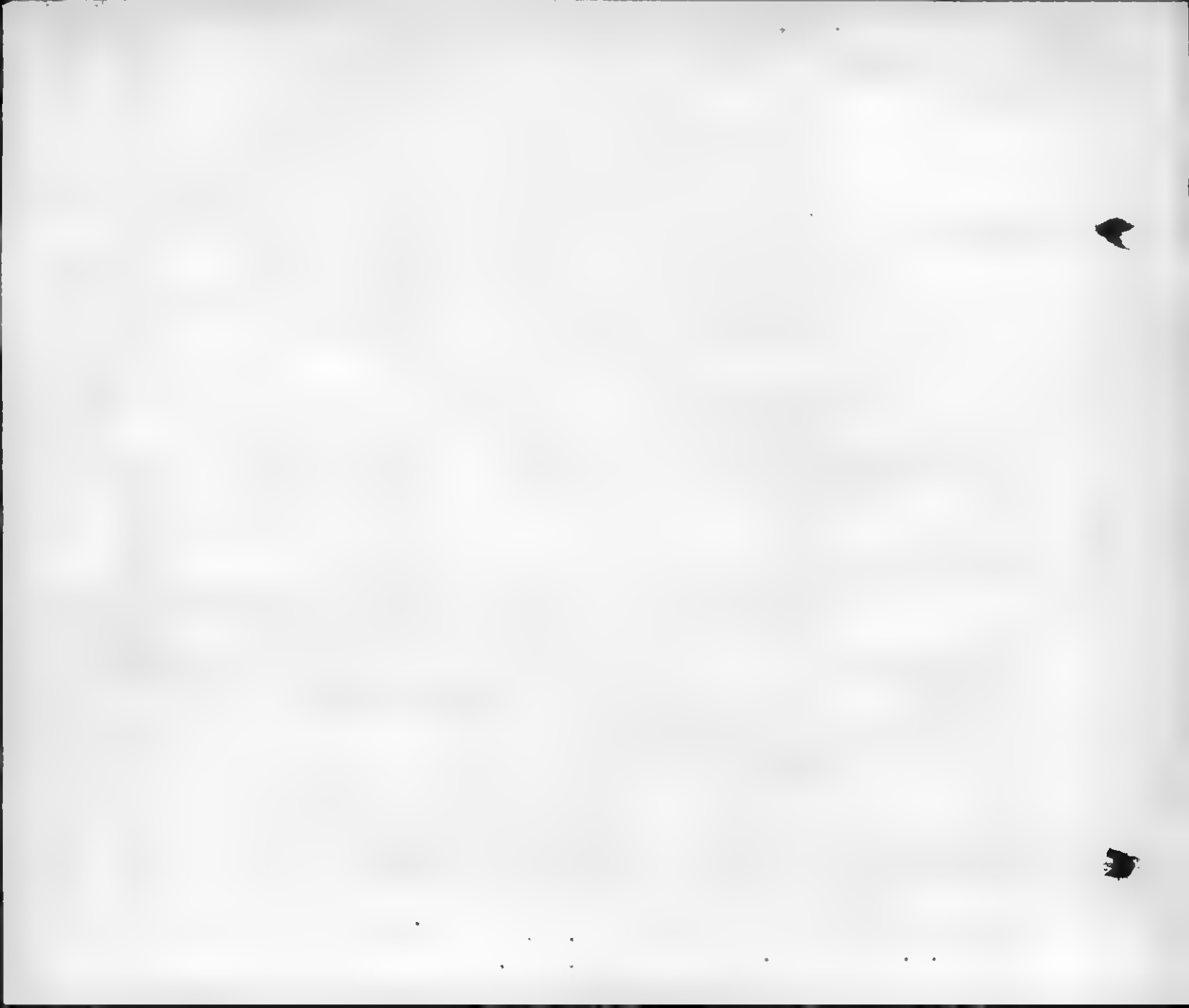
12741

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>18328 Draper Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8328 Draper Lane</u>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Leon Beckunbaugh Jr.</u>				4. DATE OF DEATH Month <u>nov</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 1911</u>	9. AGE (In years last birthday) <u>47 yrs</u>	IF UNDER 1 YEAR Months <u>47</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mathematical Engin.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cla</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas L Beckunbaugh Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Edna Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes, no, or unknown</u>				16. SOCIAL SECURITY NO <u>Daisy Beckunbaugh (wife)</u>		17. INFORMANT <u>John 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of industrial heart</u> DUE TO (b) <u>w/ metastasis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosenart</u>				DATE SIGNED <u>11-30-58</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosenart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>2901 14th St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Washington 9, D.C.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 12746 CERTIFICATE OF DEATH

12742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>82 days</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Highland Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>801 Laurel Avenue</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Betty Lou Peterson</u>			4. DATE OF DEATH Month Day Year <u>November 27, 19 58</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1932</u>		9. AGE (In years last birthday) <u>26</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			13. FATHER'S NAME <u>Russell Batt</u>		
14. MOTHER'S MAIDEN NAME <u>Mildred Roll</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>No</u>		
16. SOCIAL SECURITY NO <u>331-26-1824</u>			17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Increased Intra-Cranial Pressure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Choriocarcinoma, Metastatic</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>9 mos.</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from <u>September 6, 19 58</u> , to <u>November 27, 19 58</u> , that I last saw the deceased alive on <u>November 27, 19 58</u> , and that death occurred at <u>3:55 P.M.</u> , from the causes and on the date stated above		
ACTUAL SIGNATURE <u>Theodore L. Goodfriend</u> M.D.			ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11-27-58</u>		
PHYSICIAN'S NAME (Type) <u>Theodore L. Goodfriend, M.D.</u>			The National Institutes of Health <u>Bethesda 14, Maryland</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 11/28/58</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>	
22d. LOCATION (City, town, or county) (State) <u>N. Chicago, Illinois</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>			



12617

## CERTIFICATE OF DEATH

12743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Roma Park</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 15 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>2708 Terrapin Rd.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Scott PIGG Sr.</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-18-11</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - Mail Carrier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Yancey W. Pigg</u>				14. MOTHER'S MAIDEN NAME <u>Florine Motherly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army - WWII</u>				16. SOCIAL SECURITY NO. <u>9 -</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>						<u>7 hours</u>	
4 - DUE TO <u>Myocardial infarction</u>						<u>hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary edema</u>						<u>hours</u>	
DUE TO (c) <u>Pulmonary edema</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1958</u> to <u>Nov. 18, 1958</u> , that I last saw the deceased alive on <u>Nov. 18, 1958</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Arthur S. Kinn</u> M.D. <u>927 Broadway St.</u>				<u>11-18-58</u>			
PHYSICIAN'S NAME (Type) <u>Arthur S. Kinn</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> INC. ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>NOV 20 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12747

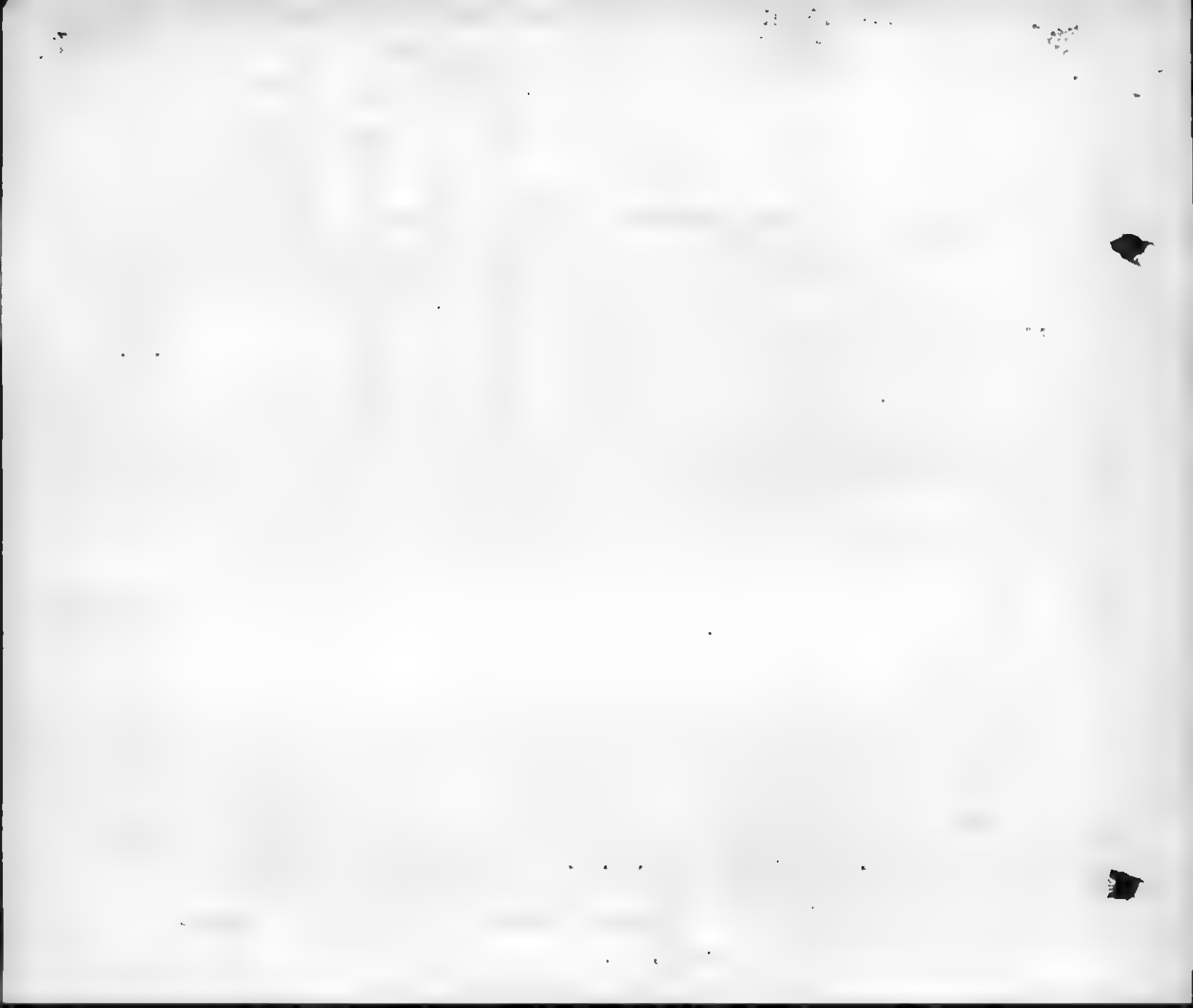
## CERTIFICATE OF DEATH

12744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>10041 Counselman Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Joseph</b> Last <b>Plenni</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1920</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreign Service Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	9. AGE (In years last birthday) <b>38</b> yrs
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph W. Plenni</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Ilse</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		18. ADDRESS <b>The Clinical Center, Bethesda 14, Maryland</b>	
1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC MYELOCYTIC LEUKEMIA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>3 YRS.</b>
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 19, 1958</b> , to <b>November 5, 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>11/5/58</b> NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND			
ACTUAL SIGNATURE <b>I. Bernard Weinstein</b> M.D.		PHYSICIAN'S NAME (Type) <b>I. Bernard Weinstein, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12748

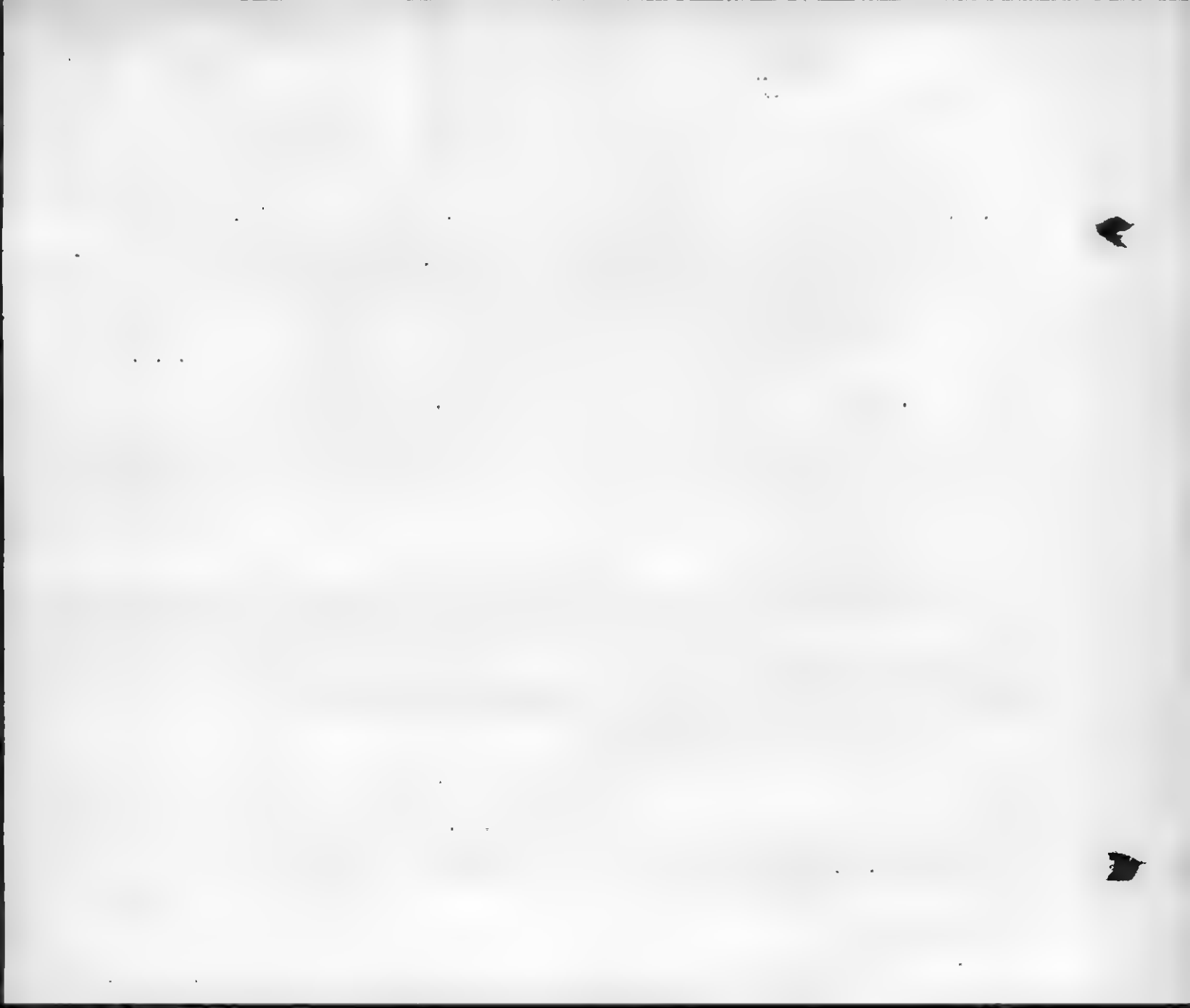
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>C</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>c/o St. Mary's Rol-A-Rink</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Leonard POOLE, JR.</b>				4. DATE OF DEATH Month Day Year <b>November 6 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-5-58</b>	
9. AGE (In years last birthday) yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Patuxent River, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James L. POOLE</b>				14. MOTHER'S MAIDEN NAME <b>Betty M. BRENSINGER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Official Navy Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.5 Hyaline membrane disease</b> DUE TO <b>Permatuity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 5, 1958</b> , to <b>November 6, 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> , and that death occurred at <b>4:15A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. L. Walton</i>		M.D. <b>U. S. Naval Hospital, NMMC</b>		DATE SIGNED <b>11-6-58</b>			
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN</b>		ADDRESS <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-12-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i> <b>R. A. Pumphrey Funeral Home, 7557 Wisc. Ave., Bethesda, Md. '58</b>				24a. REC'D BY REGISTRAR <b>DATE NOV 10 1958</b>		24b. REGISTRAR'S SIGNATURE <i>C. J. S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





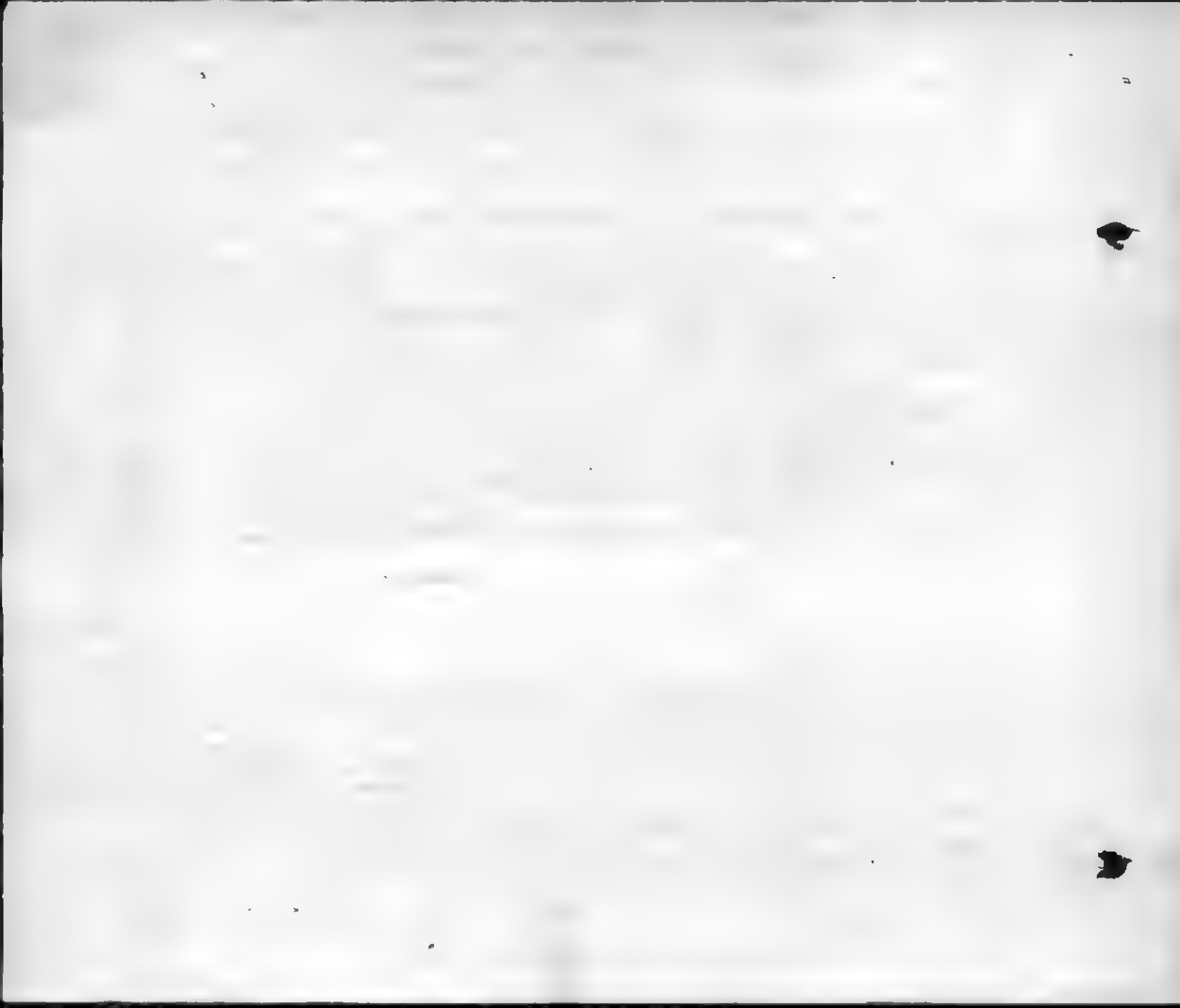
12749

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DICKERSON RTE 1</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DICKERSON RTE 1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN</b>				d. STREET ADDRESS <b>_____</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARSHALL NEWLAND POTEAT</b>				4. DATE OF DEATH Month Day Year <b>11 13 1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-15</b>	9. AGE (In years last birthday) <b>43</b> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. <b>4 10</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MARKETING SPECIALIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C.S. GOV'T.</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES S. POTEAT</b>				14. MOTHER'S MAIDEN NAME <b>MAUDE ESTELLE SIMMONS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MARY L. POTEAT</b> Address <b>DICKERSON, RTE 1, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Distention</b> X DUE TO <b>Intercerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Due to Ruptured Aneurysm of Middle Cerebral Artery</b> (b) <b>_____</b> (c) <b>_____</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month. <b>11</b>	Day. <b>13</b>	Year <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Rockville, Md.</b>	(County) <b>Montgomery</b>
21. I certify that I attended the deceased from <b>May 1953</b> , to <b>11-13, 1958</b> , that I last saw the deceased alive on <b>9-10, 1958</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>615 W. Montgomery Ave. Rockville, Md.</b>				DATE SIGNED <b>11/13/58</b>			
ACTUAL SIGNATURE <b>W. G. Hall</b>				M.D. <b>E. S. Montgomery</b>			
PHYSICIAN'S NAME (Type) <b>W. G. Hall</b>				ADDRESS <b>615 W. Montgomery Ave. Rockville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 17 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thayer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (if not in hospital, give street address) <u>Ammon's Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sadie Pratt</u>		4. DATE OF DEATH Month Day Year <u>Nov. 12, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1883</u>
9. AGE (In years last birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Carter</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles Davis</u>		Address <u>Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Metastasis from Breast</u> <u>170X</u> DUE TO <u>Carcinoma Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1947</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 28, 1932</u> , to <u>Nov. 12, 1958</u> , that I last saw the deceased alive on <u>Nov. 12, 1958</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.			
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>			
22a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>	22b. DATE THEREOF <u>11/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. EMERAL DIRECTOR'S SIGNATURE <u>Robert L. Sunden</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Robert L. Sunden</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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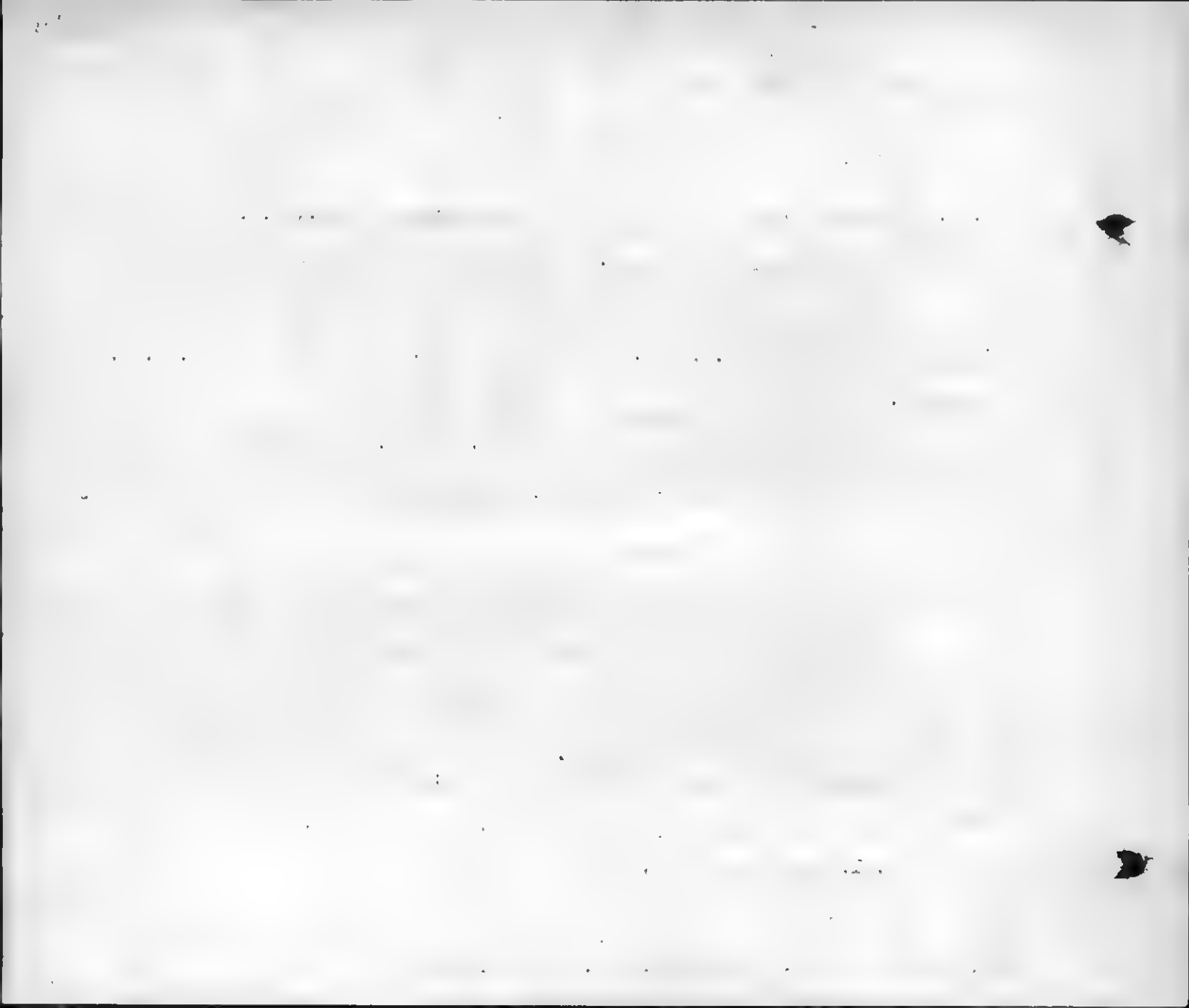
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>112 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4519 Nebraska Ave., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>J.</b> Last <b>QUICK</b>			4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>19 58</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>8-16-02</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Diplomatic Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Dept. of State</b>		11. BIRTHPLACE (State or foreign country) <b>Ind.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Walter J. QUICK</b>					
14. MOTHER'S MAIDEN NAME <b>Mary MITCHELL</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(W) Mrs. Cleo P. Quick, same as #2 above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, myelogenous, acute</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
21. I certify that I attended the deceased from <b>August 6, 1958</b> , to <b>November 26, 1958</b> , that I last saw the deceased alive on <b>November 26, 1958</b> , and that death occurred at <b>1:15 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>US Naval Hospital, NNMC</b> DATE SIGNED <b>11-26-58</b>							
ACTUAL SIGNATURE <b>J. T. Horgan</b>		M.D. <b>US Naval Hospital, NNMC</b>					
PHYSICIAN'S NAME (Type) <b>J. T. HORGAN, LCDR MC, USN</b>		<b>Bethesda, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-29-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>			
22d. LOCATION (City, town, or county) <b>Rockville</b>		(State) <b>Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dos. Gawler's Sons</b>		ADDRESS <b>1756 Renna. Ave. NW, Wash. DC</b>		24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>Carhart</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



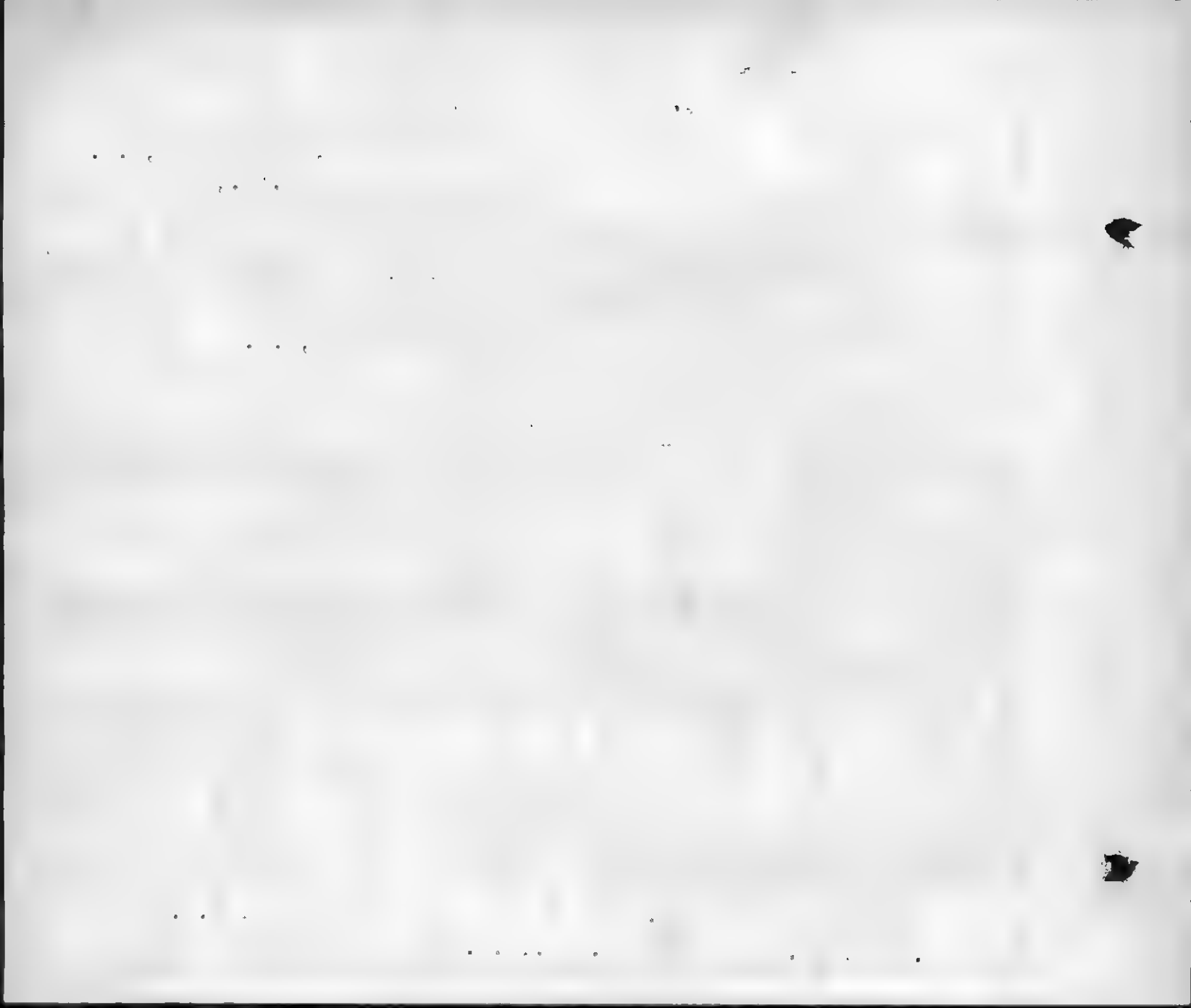
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 12752 CERTIFICATE OF DEATH

12749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5621 McLean Drive</b>		d. STREET ADDRESS <b>6141 31st. St., NW</b> <b>1621X McLean Dr. NW</b>	
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b>Cecelia</b> Last <b>Quinn</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>30</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-68</b> <b>APR 28, 1868</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	9. AGE (In years last birthday) <b>90</b> yns.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
13. FATHER'S NAME <b>Jeremiah Quinn</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Ryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. INFORMANT <b>Helen Daly</b> Address <b>5621 McLean Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>445A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>--</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>--</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 20, 1958</b> to <b>Nov 30, 1958</b> ; that I last saw the deceased alive on <b>Nov 28, 1958</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. Nolan</b> M.D.		DATE SIGNED <b>5401 Western Ave NW</b>	
PHYSICIAN'S NAME (Type) <b>JAMES E. NOLAN</b>		<b>Washington DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-2-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan, Inc.</b>		24a. REC'D BY REGISTRAR <b>DEC 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12750

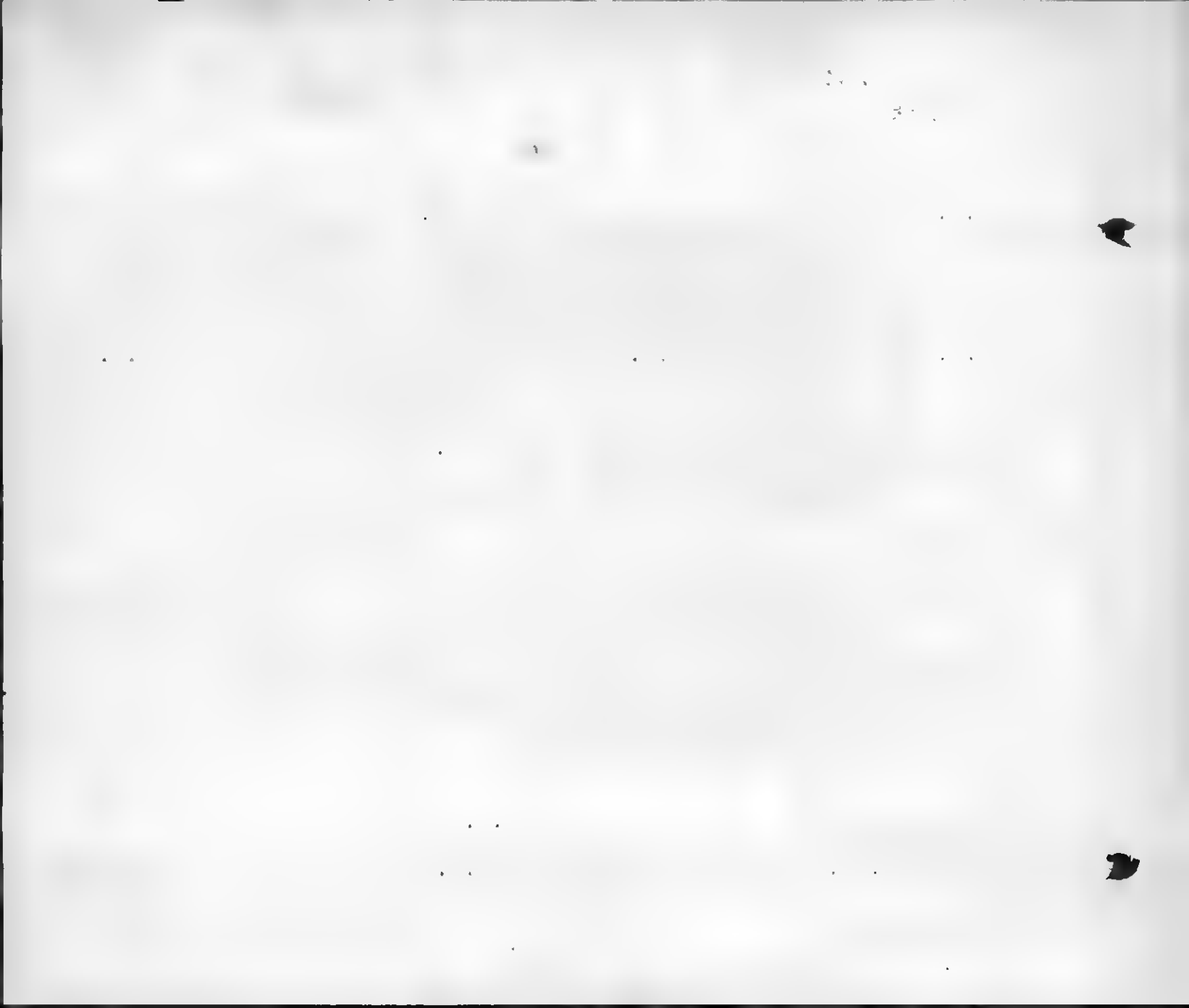
12753

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>10 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>2129 N. Thomas Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arthur Charles RAMM</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-1896</b>
9. AGE (In years last birthday) <b>62</b> yrs		IF UNDER 1 YEAR: Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min <b>27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John (n) RAMM</b>		14. MOTHER'S MAIDEN NAME <b>Johoana KRUGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>564-10-7328</b>	
17. INFORMANT <b>Alice H. RAMM</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse Metastases</b> <b>16</b> DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) <b>Bronchogenic Carcinoma (Epidermoid)</b> DUE TO (c) <b>6 mo - 1 yr.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>17 November 1958</b> to <b>27 November 1958</b> , that I last saw the deceased alive on <b>27 November 1958</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11-28-58</b> DATE SIGNED			
ACTUAL SIGNATURE <b>John W. Davis</b> M.D.		U.S. Naval Hospital, Bethesda, Md	
PHYSICIAN'S NAME (Type) <b>J. W. DAVIS, LT MC, USN</b>		U.S. Naval Hospital, Bethesda, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-1-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. J. MURPHY</b> Home <b>3524 Columbia Pike</b> ADDRESS <b>Arlington, Va.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 5</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 & 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12754

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>Bethesda</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8608 Broadmoore Dr.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>8608 Broadmoore Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edna M Ramsey</b>		4. DATE OF DEATH Month Day Year <b>Nov. 24, 1958 19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 30, 1887</b>
9. AGE (In years last birthday) <b>71 yrs</b>		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>24</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles E. Main</b>	
14. MOTHER'S MAIDEN NAME <b>Frances Lasabair</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wm. F. Ramsey</b> Address <b>Same as Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/28/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Auburn, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24. REC'D BY REGISTRAR <b>NOV 29 1958</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

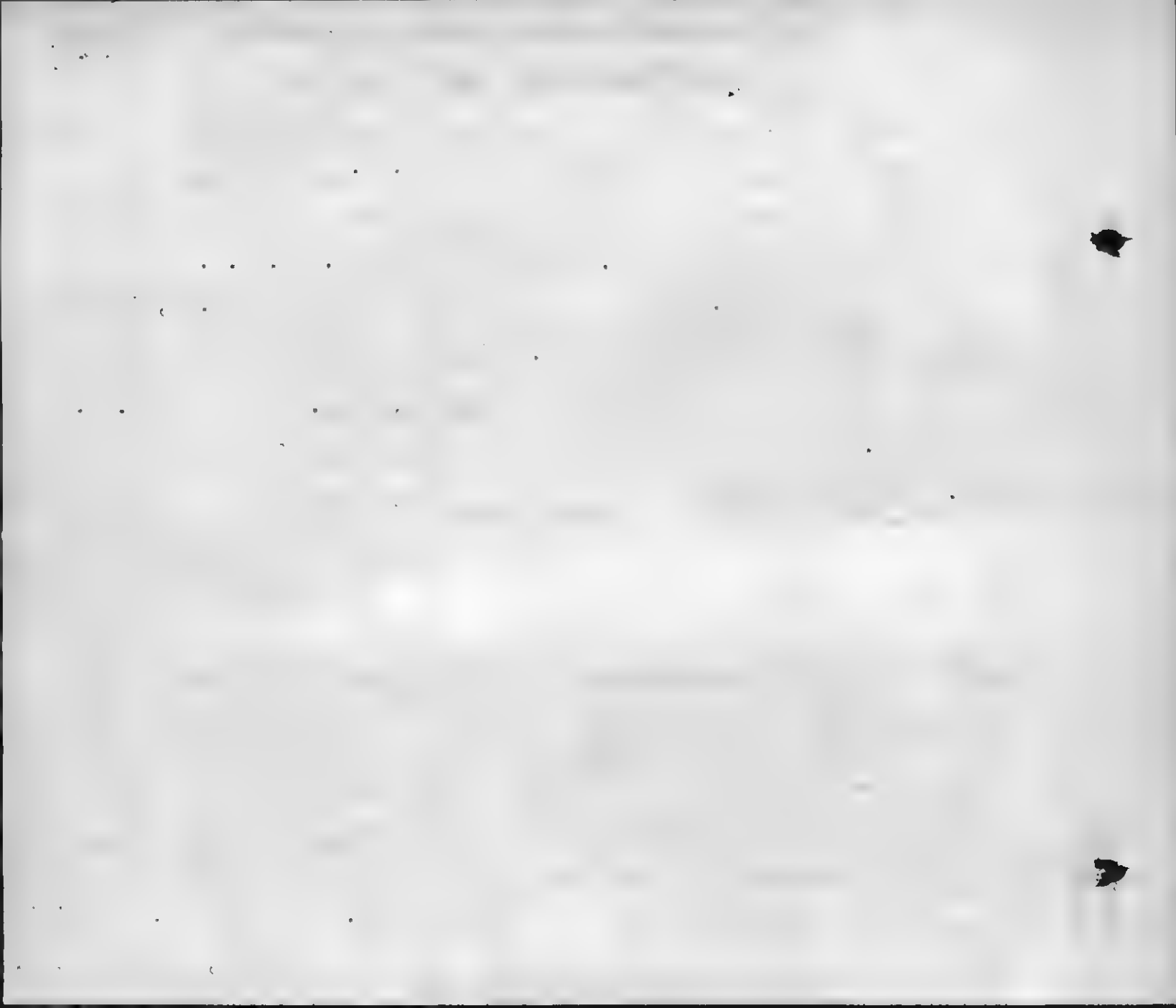
12752

12755

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>MARYLAND</u>		STATE <u>D. C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Althea Woodland Nur. Home</u>				STREET ADDRESS <u>1219 G. St. N.W.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William S. Rice</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 1, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>	8. DATE OF BIRTH <u>Oct. 1 1899</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Willard Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Memphis, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jesse M. Rice</u>				14. MOTHER'S MAIDEN NAME <u>Ida Broadway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes. World War 1 &amp; 2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Nursing Home</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Asphyxial attack</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Copypoma - bronchogenic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1958</u> to <u>Nov. 1, 1958</u> , that I last saw the deceased alive on <u>10-28-58</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above. <u>11-1-58</u>							
SIGNATURE <u>William S. Rice</u>		ADDRESS (Street, city, town, state) <u>3-00-16 St NW Wash D.C.</u>		DATE SIGNED <u>11-1-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/5/58</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Co., Virginia</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heatley Funeral Home</u>		ADDRESS <u>Alexandria, Va.</u>	



12753

Item 18 Film 236 12-11-58 amc

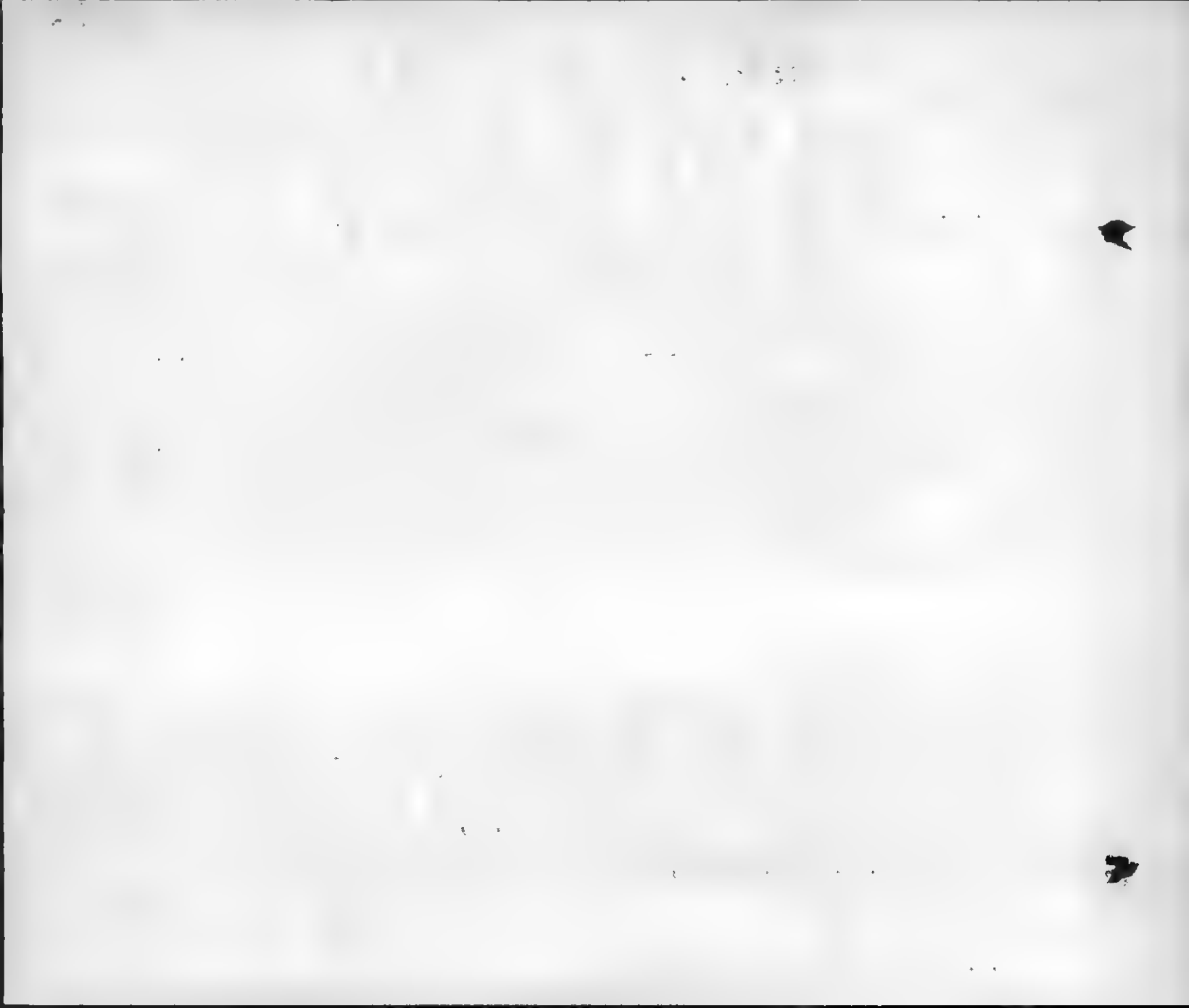
12756

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>		d. STREET ADDRESS <b>Route #2, Box 215</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emily</b> Middle <b>Elizabeth</b> Last <b>RINARD</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>19 58</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-10-08</b>		9. AGE (In years last birthday) <b>50</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harry Solomon SHUEY</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Levina TYLER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(H) Ellis B. Rinard, same as #2 above</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary site: Right breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Arlington</b>		(County) <b>Virginia</b>		(State) <b>Virginia</b>		21. I certify that I attended the deceased from <b>November 10, 19 58</b> , to <b>November 30, 19 58</b> , that I last saw the deceased alive on <b>November 30, 19 58</b> , and that death occurred at <b>7:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b> DATE SIGNED <b>12-1-58</b>			
22a. BURIAL CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington</b>		22e. (State) <b>Virginia</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>D. R. KOTH, LT, MC, USN</b>		24a. REC'D BY REGISTRAR <b>DEC 3 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>		24c. DATE <b>DEC 3 58</b>		24d. ADDRESS <b>Bethesda 14, Maryland</b>		24e. SIGNATURE <b>D. R. KOTH</b>		24f. DATE <b>12-1-58</b>		24g. ADDRESS <b>Bethesda 14, Maryland</b>		24h. SIGNATURE <b>D. R. KOTH</b>	

VS A15 (4)  
15M 10/57





12757

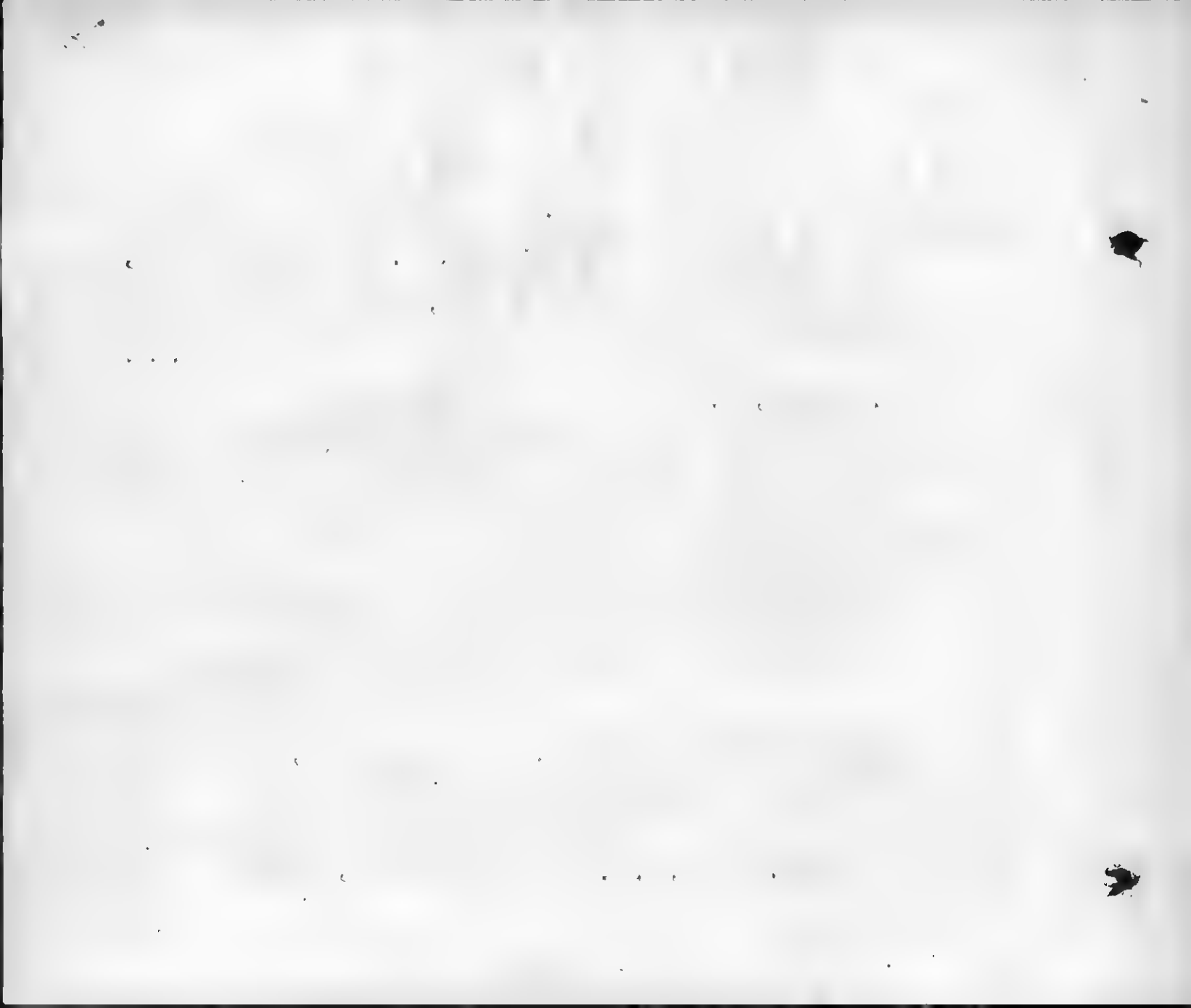
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>84 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Stephens City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>Charles Oliver Ritenour, Jr.</b>			4. DATE OF DEATH Month Day Year <b>November 2, 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 9, 1946</b>		9. AGE (In years last birthday) <b>12 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles O. Ritenour, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Mary Cave</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Diathesis, of</b> DUE TO <b>Brain, Esophagus, Tubercle &amp; Kidney</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1 yr</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 10, 1958</b> , to <b>November 2, 1958</b> , that I last saw the deceased alive on <b>November 2, 1958</b> , and that death occurred at <b>2:40 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Nathan S. Taylor, M.D.</b> <b>The Clinical Center</b> <b>11/3/58</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Macadonia</b>	
22d. LOCATION (City, town, or county) (State) <b>Frederick County, Virginia</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey-Bethesda, Maryland</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

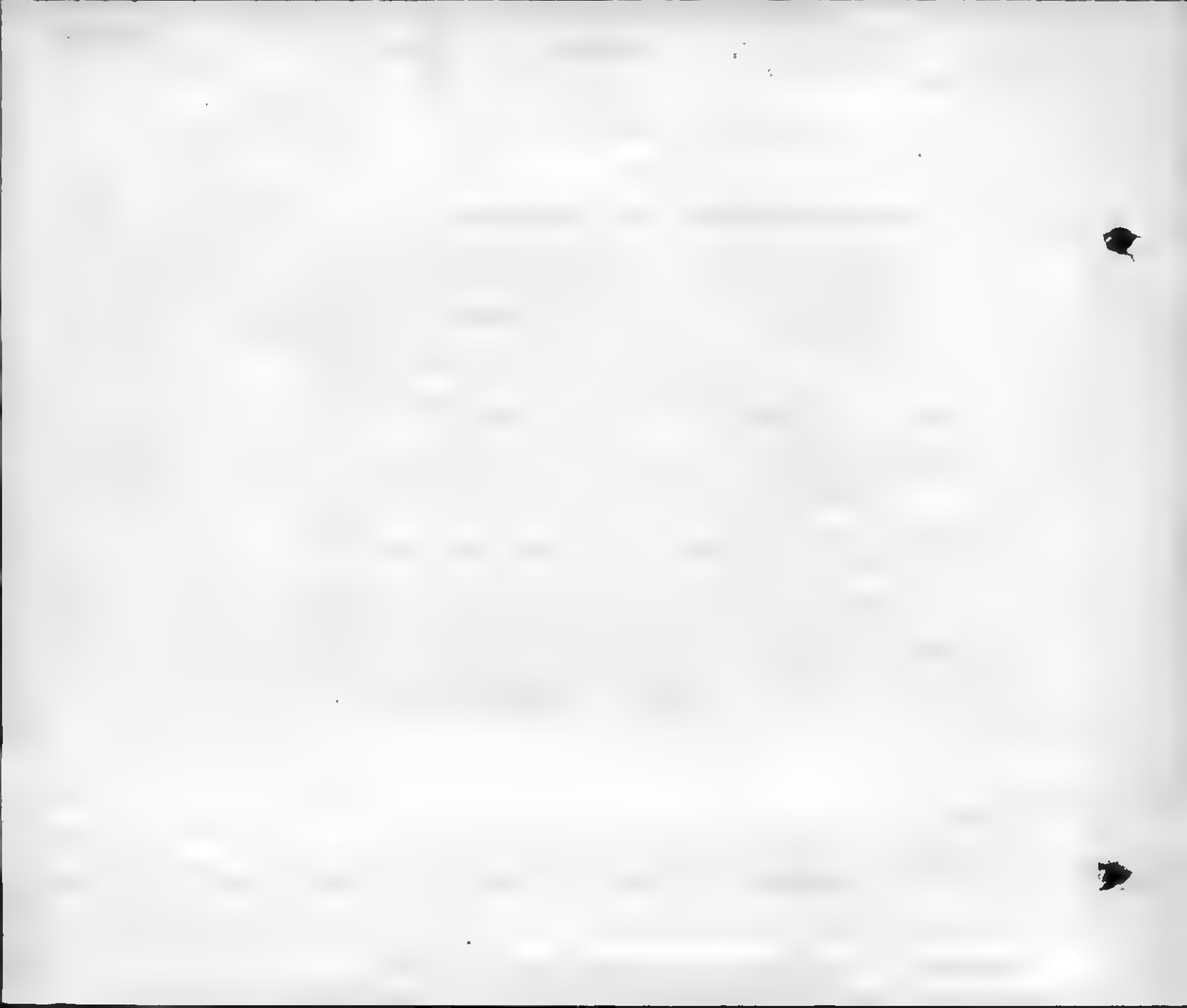
12758

CERTIFICATE OF DEATH

12755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		d. STREET ADDRESS <u>4901-42nd Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>OLEGIA</u> Middle <u>BELL</u> Last <u>ROBINSON</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/1890</u>
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Assistant</u>	
11. BIRTHPLACE (State or foreign country) <u>Ala</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Brittian</u>		14. MOTHER'S MAIDEN NAME <u>Pokey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Harry T. Robinson</u> Address <u>Rou</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 23, 1954</u> to <u>NOV. 17, 1958</u> , that I last saw the deceased alive on <u>NOV. 17, 1958</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5206 Norwood Dr.</u> DATE SIGNED <u>11/17/58</u> ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D. <u>Cherry Chase, Md.</u> PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>NOV 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>



12759

## CERTIFICATE OF DEATH

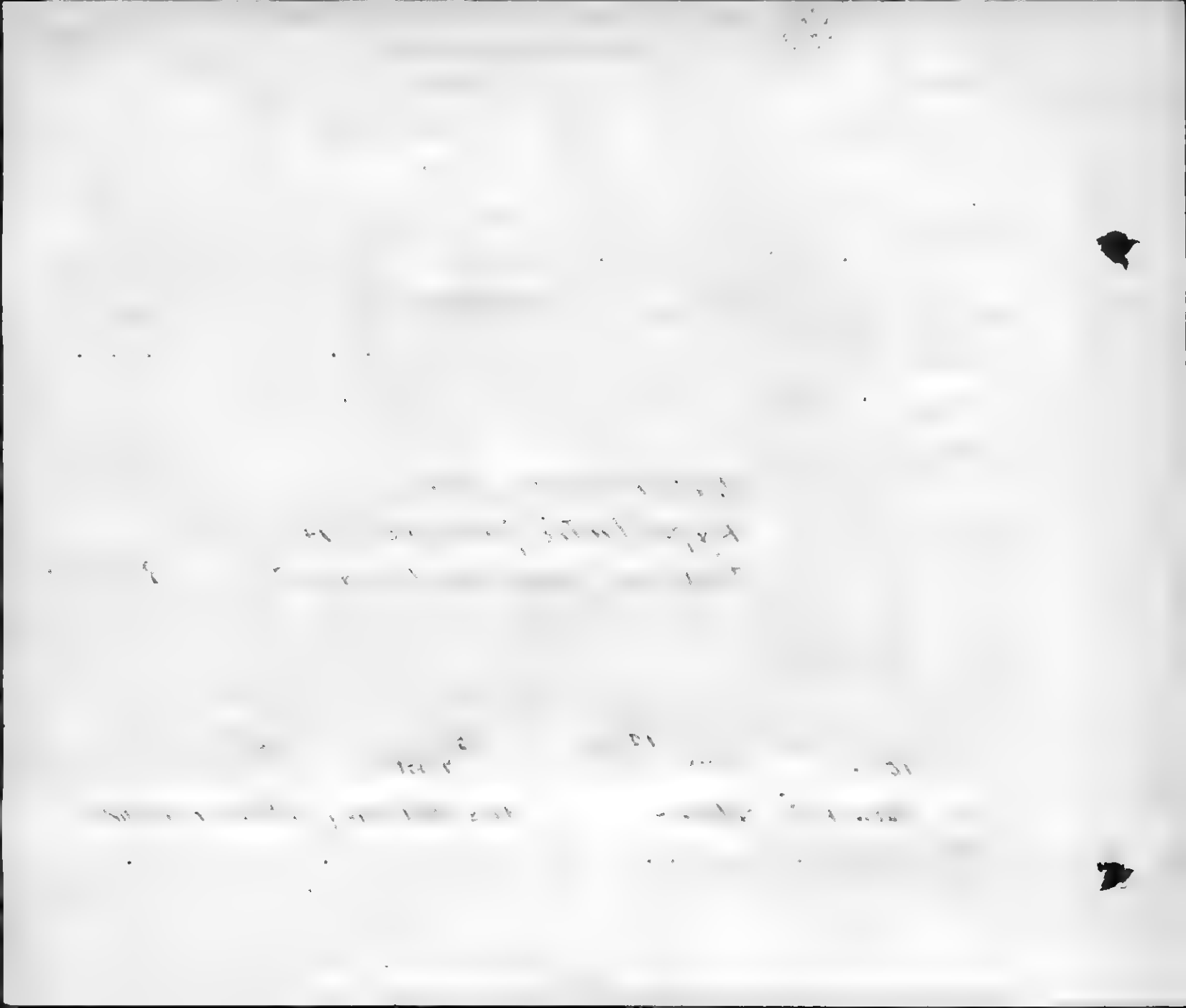
12756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Ida</b>	
c. LENGTH OF STAY IN 1b <b>22 years</b>		d. STREET ADDRESS <b>Asbury Methodist Home</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Elma C. Rowland</b>		4. DATE OF DEATH Month Day Year <b>November 4 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 22, 1866</b>
9. AGE (In years last birthday) <b>92 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newbern, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James F. Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Amenda V. Kistler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPOSTATIC PNEUMONIA</b> (c) <b>CEREBRAL VASCULAR ACCIDENT</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8-29-58</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-21</b> , 19 <b>55</b> , to <b>11-4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10-29</b> , 19 <b>58</b> , and that death occurred at <b>9:55 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4208 Anthony St., Kensington, Md. 11-4-58</b>			
ACTUAL SIGNATURE <b>Sarah E. Glover</b>		M. D. <b>4208 Anthony St., Kensington, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover, M.D.</b>		<b>4208 Anthony St., Kensington, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11/6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Fortune Gaithersburg Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12760

## CERTIFICATE OF DEATH

12757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>6 months</b>		d. STREET ADDRESS <b>1608 East-West Highway</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1608 East-West Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>CLARA</b> Last <b>SANDERSON</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>2</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 6, 1866</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>FT. FOOTE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS H. GRAY</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN SCHAEFFER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Geo. T. Robey, 1608 East-West Highway</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC LYMPHATIC LEUKEMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 M.O.S.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONGESTIVE HEART FAILURE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE</b> , 1958, to <b>2 NOV.</b> , 1958, that I last saw the deceased alive on <b>2 NOV.</b> , 1958, and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L.B. Snow</b>		M.D. <b>9013 FLOWER AVE.</b> <b>11/2/58</b>	
PHYSICIAN'S NAME (Type) <b>L. B. SNOW</b>		<b>SILVER SPRING, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b>		22b. DATE THEREOF <b>11/5/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN MAUSOLEUM</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b> <b>Raymond A. Burke</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John S. H. H.</b>	

MEDICAL CERTIFICATION

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

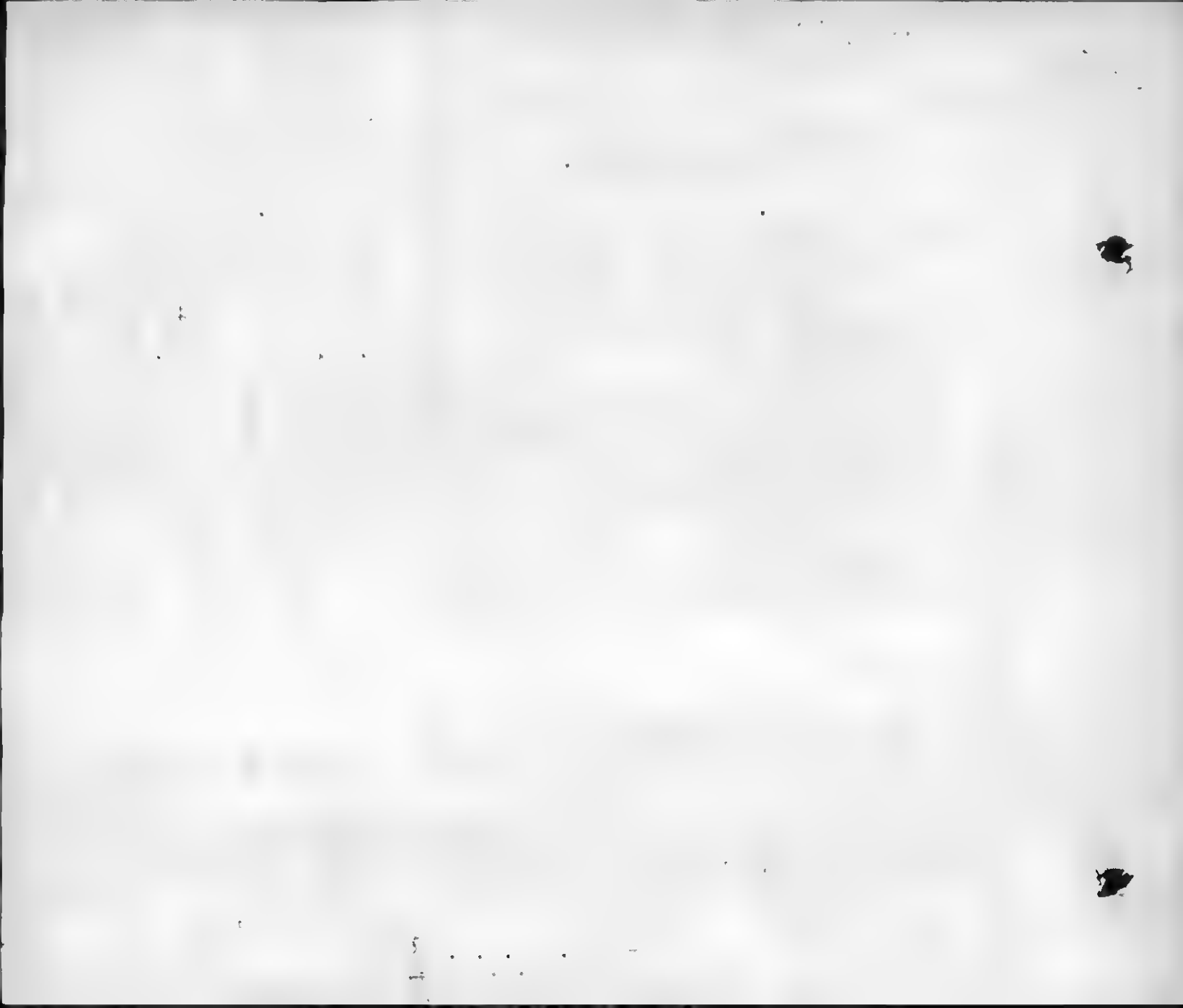
12758

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>8215 Old Georgetown Rd Bethesda</u> c. LENGTH OF STAY IN 1b <u>few min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beth-ell Synog.</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4700 Bradley Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nathan L Sanow</u> First Middle Last <b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>22 Oct 1891</u> <b>9. AGE</b> (in years) <u>67</u> yrs <b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>12</u> <b>IF UNDER 24 HRS.</b> Hours <u></u> Min <u></u>			<b>4. DATE OF DEATH</b> <u>Nov. 4, 1958</u> Month Day Year <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Engr</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Rochester N. Y.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>Louis Sanow</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO</b> <u>Yes</u> <b>17. INFORMANT</b> <u>Son</u> Address <u>Kenneth Sanow 6525 Elgin Lane Beth Md</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann (Unknown)</u> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause last. DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <u></u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18) <u></u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u> <b>20f. (City or town)</b> (County) (State) <u></u>			<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>11/4/58</u>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>11/6/58</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Britton Road</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>Rochester, New York</u>			<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Goldberg Funeral Home</u> ADDRESS <u>4217 - 9th. St. N.W. Washington, D.C.</u> <b>24a. REC'D BY REGISTRAR</b> <u>NOV 6 '58</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kiser</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12762

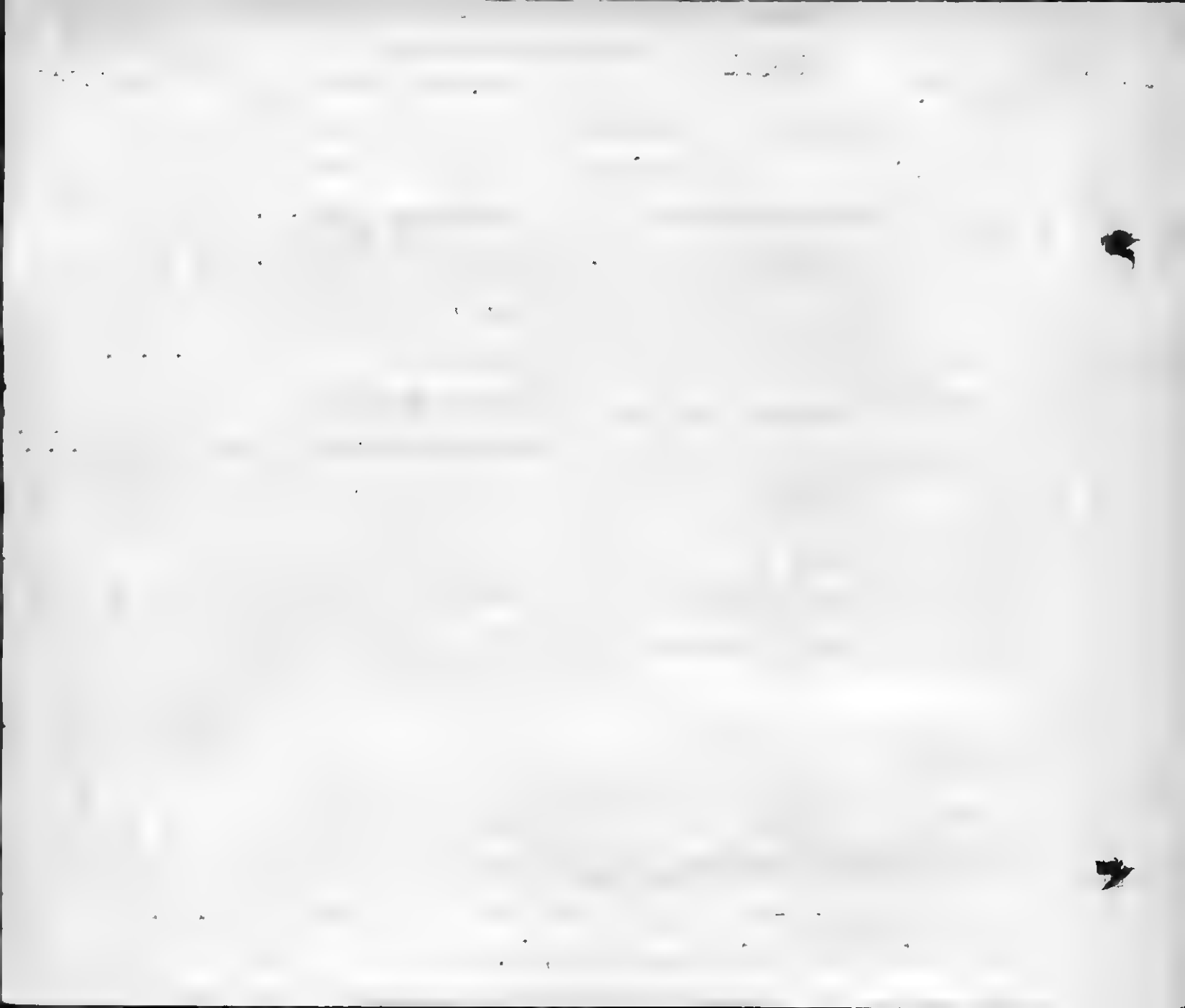
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>594 University Blvd. E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>M.</u> Last <u>Scarlis</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 5, 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>		IF UNDER 24 HRS Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Riley</u>				14. MOTHER'S MAIDEN NAME <u>Louise Dunnigan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Miss Shirley Scarlie</u> Address <u>(Silver Spring, Md.) 594 University Blvd. E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast with</u> <u>110X</u> DUE TO <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>Aug</u> Day <u>9</u> Year <u>1958</u> Hour <u>11</u> a. m. <u>00</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>217 University Blvd E</u>	
20f. (City or town) <u>Silver Spring, Md.</u>				20g. (County) <u>Montgomery Co.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Aug 9, 1958</u> to <u>Nov 9, 1958</u> , that I last saw the deceased alive on <u>Nov 9, 1958</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard G. Fitzgerald</u> M.D.				ADDRESS (Street, city or town, state) <u>217 University Blvd E</u>		DATE SIGNED <u>11/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Bernard Fitzgerald</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey Inc.</u>				24a. REC'D BY REGISTRAR <u>Raymond A. Jaska</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	
ADDRESS <u>8434 Georgia Ave.</u>				DATE <u>NOV 12 '58</u>			
<u>Silver Spring, Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12763

## CERTIFICATE OF DEATH

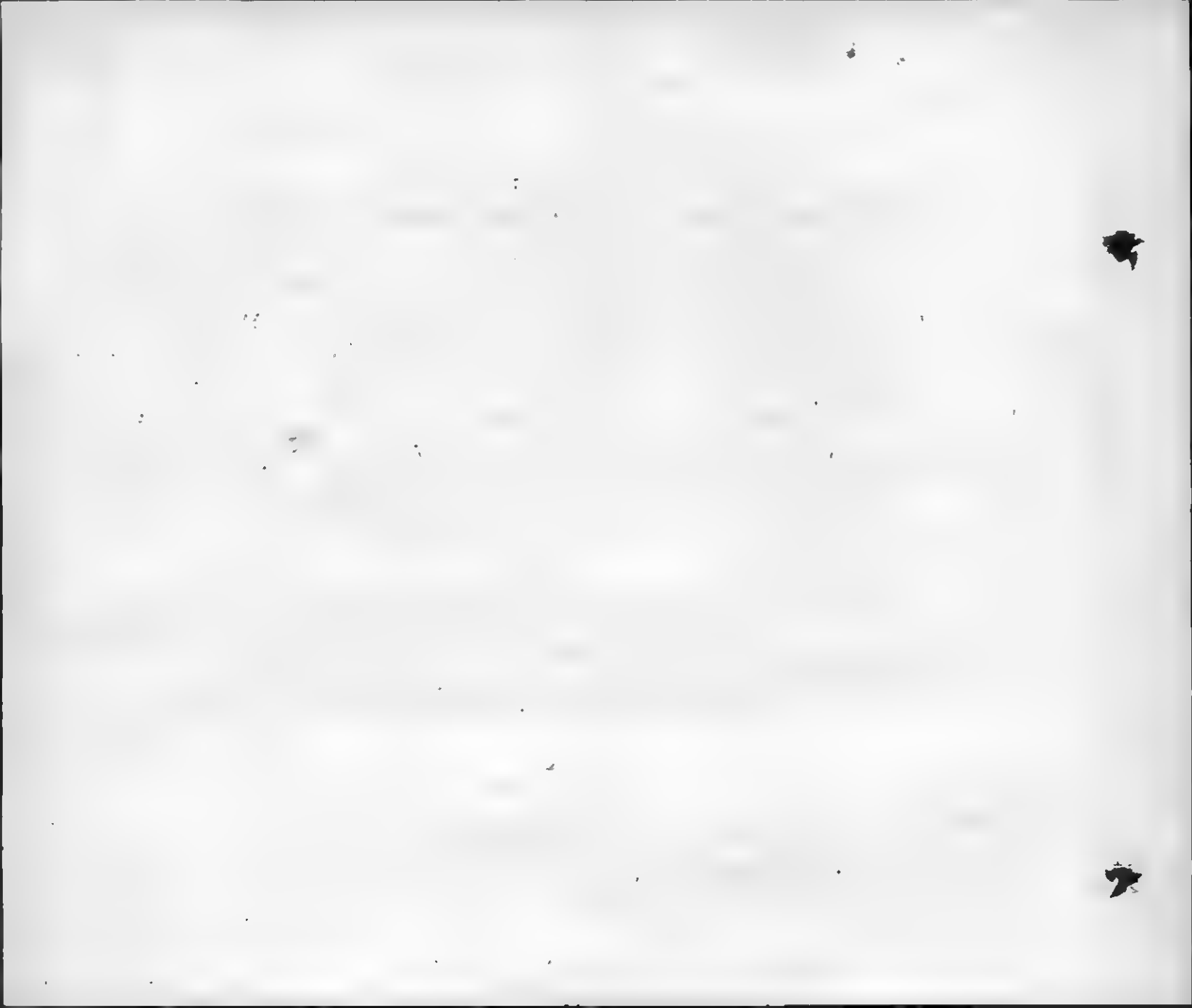
12760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>20 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>1406 Kanawha Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Linda Darlene Schmidt</u>		4. DATE OF DEATH Month Day Year <u>November 15, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1947</u>
9. AGE (In years last birthday) <u>11</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harvey D. Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Lena Montgomery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>TETRALOGY OF Fallot-postoperative</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 26, 1958</u> to <u>November 15, 1958</u> , that I last saw the deceased alive on <u>November 15, 1958</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>11-15-58</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
ACTUAL SIGNATURE <u>Leon I. Goldberg</u> M.D.		PHYSICIAN'S NAME (Type) <u>Leon I. Goldberg, M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 18, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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CERTIFICATE OF DEATH

12761

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. STREET ADDRESS <b>Route #1</b>	
3. NAME OF DECEASED (Type or print) First <b>Christine</b> Middle <b>Mary</b> Last <b>Seabolt</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1936</b>
9. AGE (In years last birthday) <b>22 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b> Hours <b>14</b>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ernest Atwell</b>		14. MOTHER'S MAIDEN NAME <b>Zenola Tibbs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-6744</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Uremia</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 months</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/28</b> , 19 <b>58</b> , to <b>11/24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/24</b> , 19 <b>58</b> , and that death occurred at <b>6:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b> DATE SIGNED <b>11/25/58</b> ACTUAL SIGNATURE _____ M.D. <b>Sandy Spring, Maryland</b> PHYSICIAN'S NAME (Type) <b>C. H. Ligon, M. D.</b> <b>Sandy Spring, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE <b>11/28/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 28 58</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. S. Brand</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12765

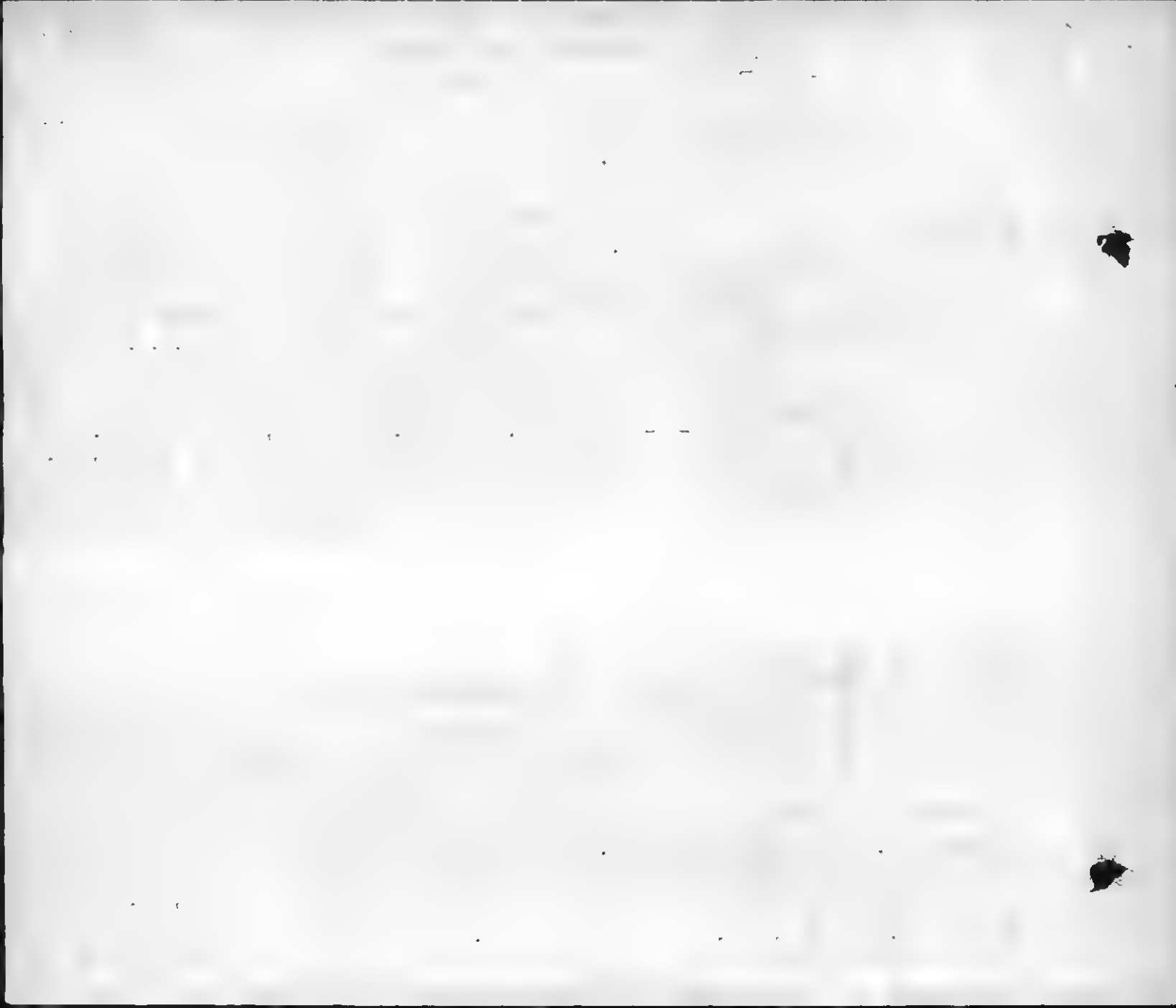
CERTIFICATE OF DEATH

12762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>28 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>9205 2nd Avenue</b>				e. STREET ADDRESS <b>9205 2nd Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>REBECCA</b> Middle <b>C.</b> Last <b>SHAW</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/74</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown Shearin</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>577-10-0420-A</b>		17. INFORMANT <b>Mrs. Calvin W. Schaeffer, 9205 2nd Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b> DUE TO <b>42a.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>MYOCARDITIS AND MILD</b> DUE TO <b>CHRONIC</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>NONE</b>					
20c. TIME OF INJURY Month <b>Nov</b> Day <b>19</b> Year <b>19</b> Hour a. m. p. m. <b>NONE</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>	20f. (City or town) <b>X</b>	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>1954</b> to <b>15 Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6 Nov</b> , 19 <b>58</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Silver Spring, Md.</b> DATE SIGNED <b>Marshall Cuvillier, Jr.</b>							
ACTUAL SIGNATURE <b>Marshall Cuvillier, Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>L. MARSHALL CUVILLIER, JR.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/18/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12766

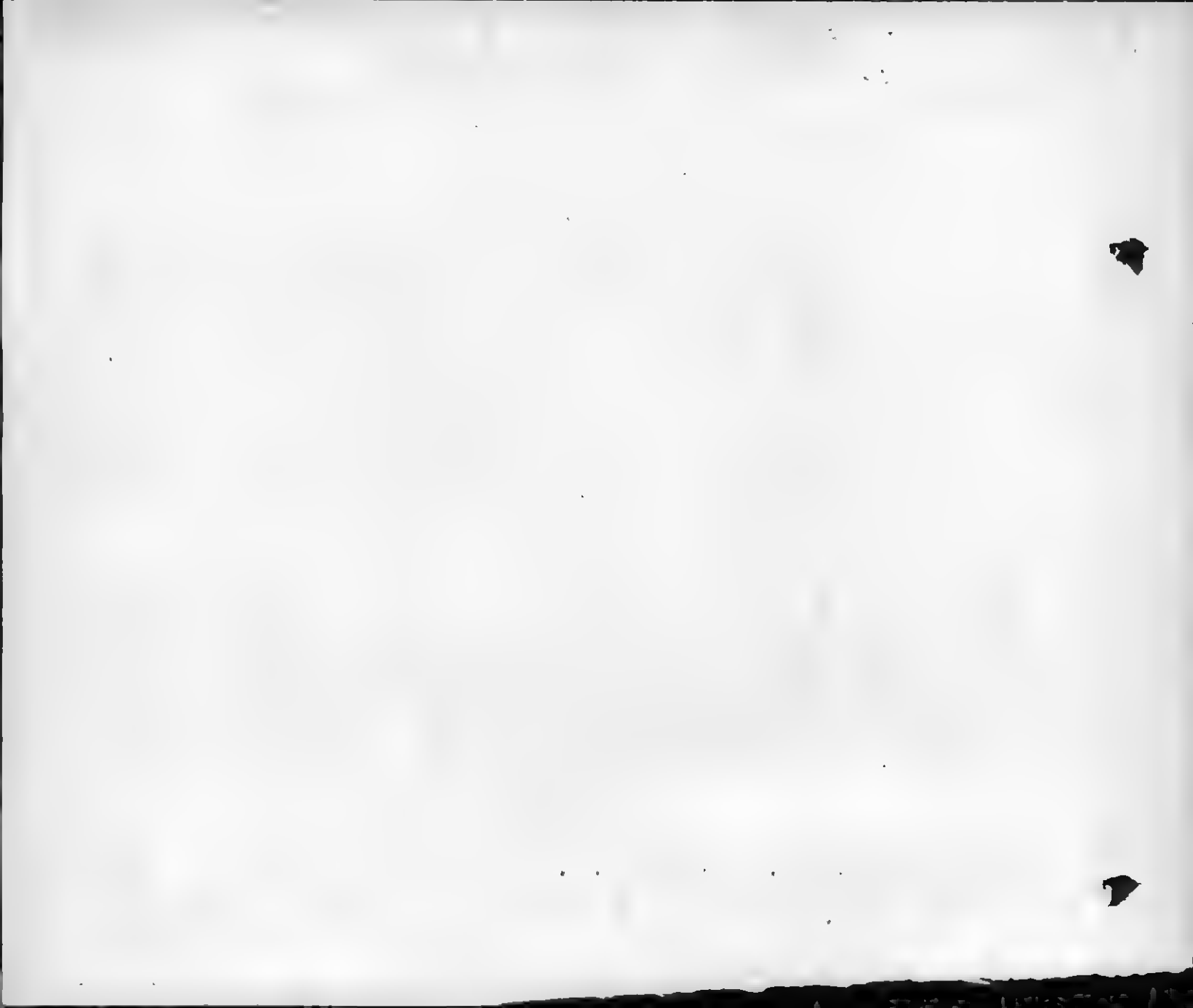
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>California</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>46 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Los Angeles 56</u> <u>3 X 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>5918 Wooster Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Rhoda</u>		First <u>(none)</u>		Middle <u>(none)</u>		Last <u>Sherbecoe</u>	
4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>19 58</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>October 26, 1923</u>		9. AGE (In years lost birthday) yrs <u>35</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel J. Ross</u>				14. MOTHER'S MAIDEN NAME <u>Sophia London</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>046-18-5448</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System Depression</u> <u>195.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Adeno-Carcinoma</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>1 year</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 8, 1958</u> , to <u>November 23, 1958</u> , that I last saw the deceased alive on <u>November 23, 1958</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>11/23/58</u> The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE <u>Theodore L. Goodfriend</u> M.D.		PHYSICIAN'S NAME (Type) <u>Theodore L. Goodfriend, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 27, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillside Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Los Angeles, California</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. K. ...</u>				ADDRESS <u>3501-14 St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

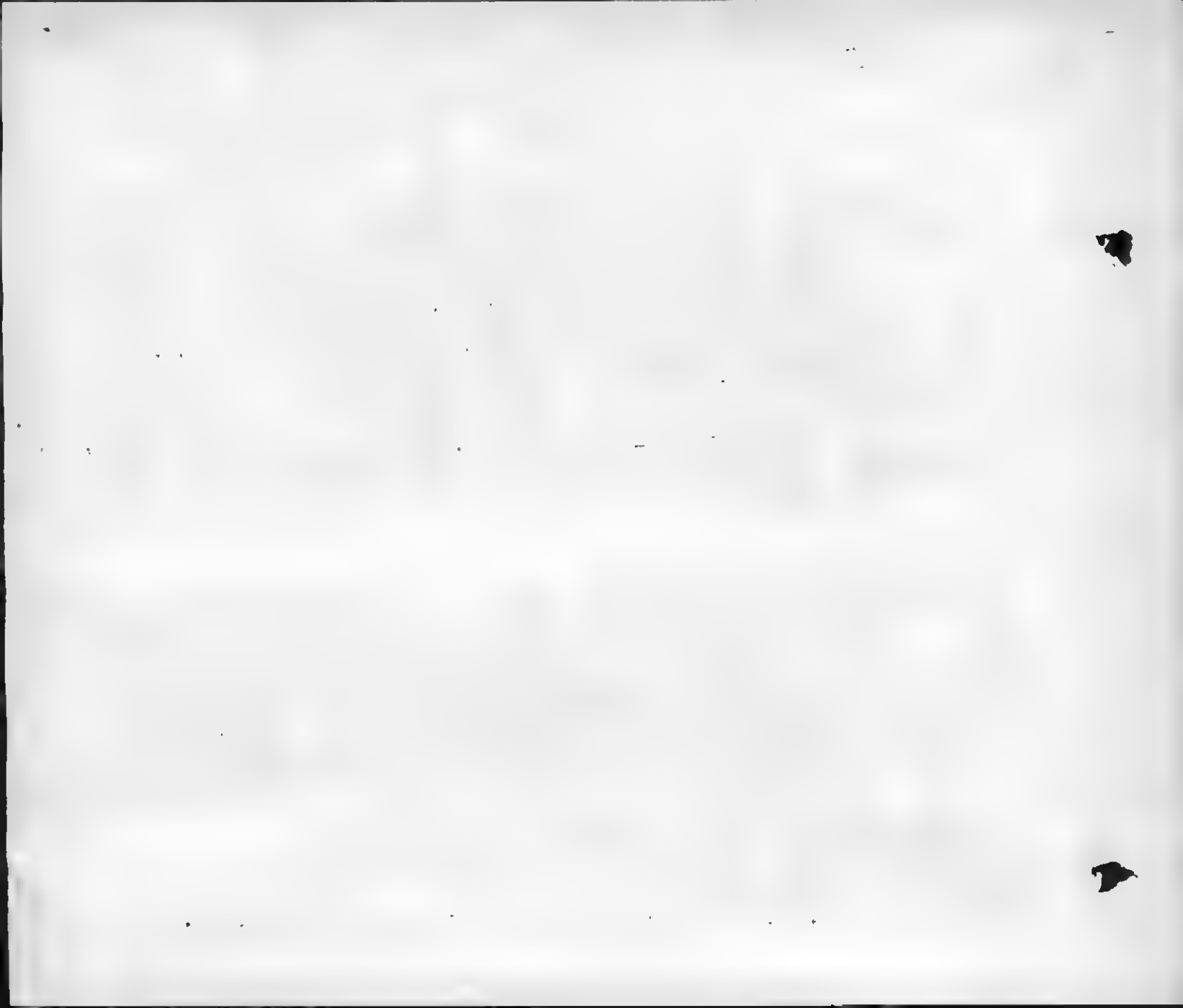
**12764**

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>43 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>11005 Locust Drive</u>		
3. NAME OF DECEASED (Type or print) <u>Eloise</u>			4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1902</u>		9. AGE (in years last birthday) <u>56</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker-Telephone operator at</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Naval Med. Center</u> <u>Frank Hilton</u>			14. MOTHER'S MAIDEN NAME <u>Hallie Bohrer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-8532</u>		17. INFORMANT <u>Gladys V. White</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral contusion &amp; laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell down basement steps at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12 am 11-23 1958</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>home</u>	
		20f. (City or town) <u>Damascus Monty Md</u>		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschaut</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschaut</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 27, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Methodist</u>	
				22d. LOCATION (City, town, or county) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mofiswith</u>			24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12768

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brinklow</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brinklow</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brighten Dam Rd.</b>				STREET ADDRESS <b>Brighten Dam Rd.</b>		e. IS RES. DENCE ON A FARM. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sydney Snowden Stabler</b>				4. DATE OF DEATH <b>Nov. 11, 1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1889</b>		9. AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired U.S. Agriculturist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ma.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Augustas Stabler</b>				14. MOTHER'S MAIDEN NAME <b>Helen Snowden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Sidney Stabler Jr., Brookville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4-20-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found dead in bed.</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION OR REMOVAL (Specify) <b>Cremation NOV. 11</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		ADDRESS <b>Laytonsville, Md</b>		24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H. H.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





12769

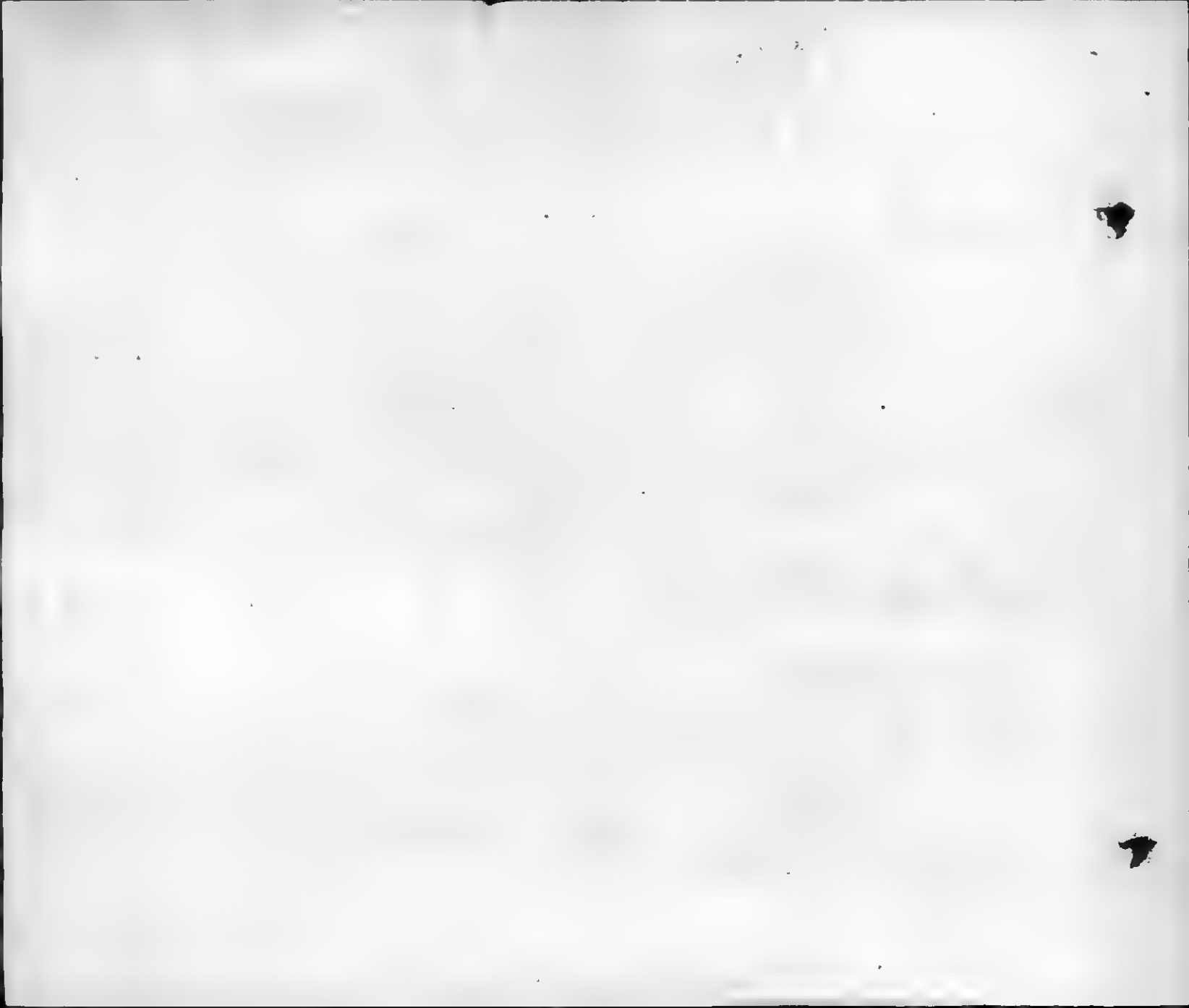
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, on residence before admission) a. STATE <b>South Carolina</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charleston</b>	
f. STREET ADDRESS <b>The Citadel</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Henry Starr</b>		4. DATE OF DEATH Month Day Year <b>November 11 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 26, 1953</b>
9. AGE (In years last birthday) <b>5</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert C. Starr</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Brixon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>540.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>surgery for bleeding gastric ulcer</b> (c) <b>post-operative status - closure of peritoneal cavity</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b> <b>9 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (GIVEN IN PART I (a)) <b>congestive heart failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 October 1958</b> to <b>November 11, 1958</b> , that I last saw the deceased alive on <b>November 11, 1958</b> , and that death occurred at <b>3:45 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 11/11/58</b> <b>National Institutes of Health</b>			
ACTUAL SIGNATURE <b>William W. Pfaff</b> M.D.		PHYSICIAN'S NAME (Type) <b>William W. Pfaff, M.D.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>11/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

12618

Item 14 Film G236 11-20-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12767

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNKNOWN TOWN</u>				c. LENGTH OF STAY IN 1b <u>10-12 New Hampshire Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNKNOWN</u>				d. STREET ADDRESS <u>White Oak, Silver Spring</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRVIN T. STUART</u>				4. DATE OF DEATH Month Day Year <u>11 13 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 5, 1895</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVAL ORD.</u>		11. BIRTHPLACE (State or foreign country) <u>EMERSON VALLEY, PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JACOB STEWART</u>				14. MOTHER'S MAIDEN NAME <u>"Not available"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs GERTRUDE E. STEWART</u>				Address <u>10902 N. H. AVE., S.S. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infarction massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>Nov 1, 1958</u> , to <u>Nov 13, 1958</u> , that I last saw the deceased alive on <u>Nov 13, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest A. Sarao</u>				ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave. Silver Spring, Md.</u> DATE SIGNED <u>11/14/58</u>			
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hall</u> ADDRESS <u>254 CARROLL ST. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William J. H. H.</u>	



## BALTIMORE, 18

12770

## CERTIFICATE OF DEATH

Reg. Dist. No.

12768

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c LENGTH OF STAY IN lb <u>7 hours</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e STREET ADDRESS <u>Brookeville</u>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Strickland</u> Last <u>Strickland</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 71</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min <u>87</u>	IF UNDER 24 HRS Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min <u>87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the left breast</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 7, 19 58</u> to <u>November 9 19 58</u> , that I last saw the deceased alive on <u>November 9, 19 58</u> , and that death occurred at <u>8:45pm</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u> DATE SIGNED <u>11-10-58</u>			
ACTUAL SIGNATURE <u>Clarksville, Md.</u>		PHYSICIAN'S NAME (Type) <u>Clarksville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Nov. 10</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Newport</u>	22d. LOCATION (City, town, or county) (State) <u>Newport New Hampshire</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the pages should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12771

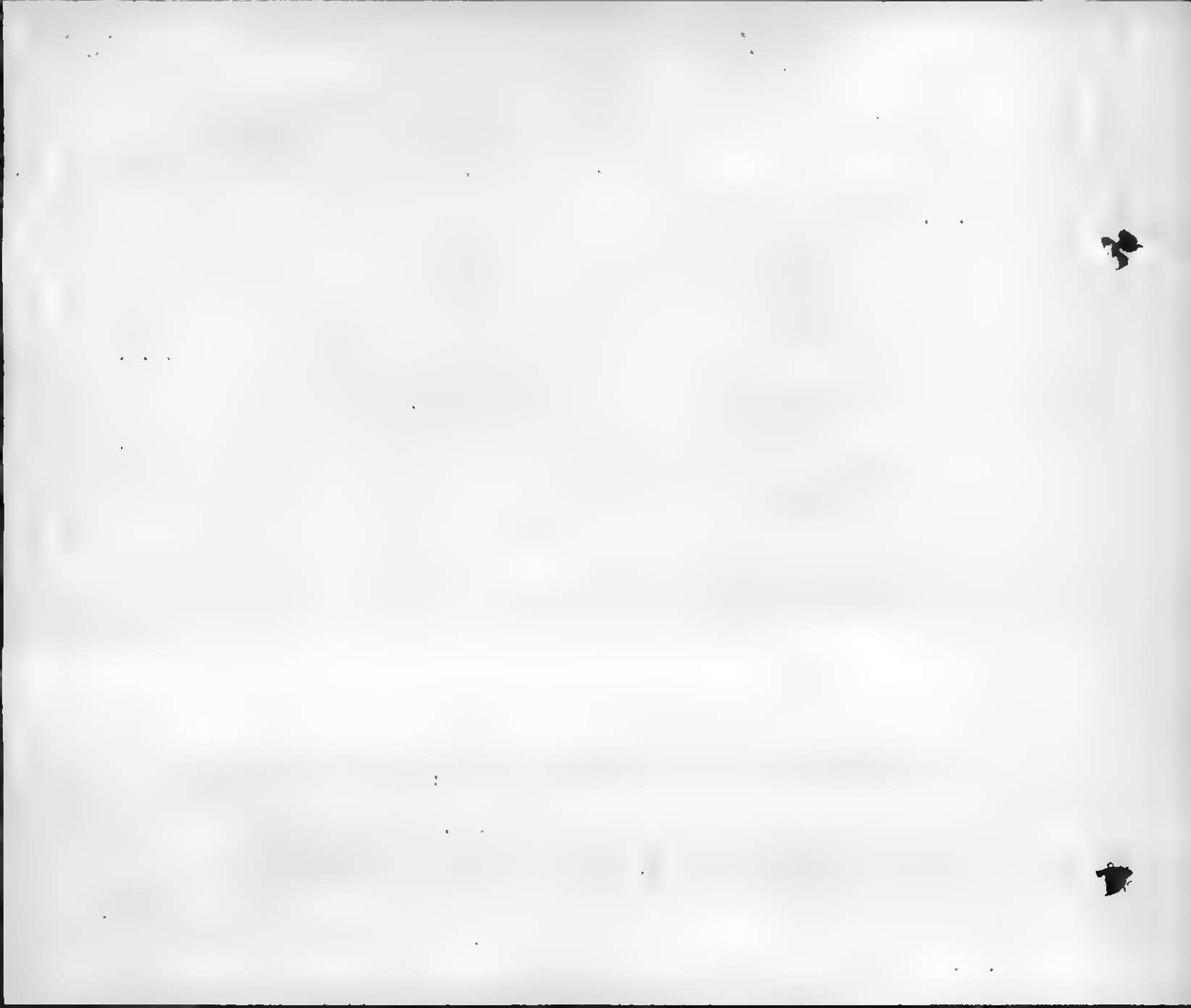
## CERTIFICATE OF DEATH

12769

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4½ hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admnssn) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Washington Forest (Washington 22, D. C.)</b> d. STREET ADDRESS <b>8519 Van Buren Drive</b> e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Karen</b> First <b>Bradford</b> Middle <b>STRUVEN</b> Last			4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-58</b>		9. AGE (In years last birthday) yrs <b>4</b> Months <b>32</b> Days <b>4</b> Hours <b>32</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>	
13. FATHER'S NAME <b>Robert L. STRUVEN</b>			14. MOTHER'S MAIDEN NAME <b>Marion B. POWERS</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>(F) Robt. L. Struven, same as #2 above.</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hyaline Membrane Disease</b> <b>773.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>November 24, 1958</b> , to <b>November 24, 1958</b> , that I last saw the deceased alive on <b>November 24, 1958</b> , and that death occurred at <b>9:17 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b> DATE SIGNED <b>11-25-58</b>					
ACTUAL SIGNATURE <b>David Harris</b> M.D. <b>U. S. Naval Hospital, NNMC</b>					
PHYSICIAN'S NAME (Type) <b>David HARRIS, LT MC, USN</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>11-26-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hills</b>	
22d. LOCATION (City, town, or county) <b>Suitland</b>		22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey Funeral Home, 7557 Wisc. Ave.</b>			24a. REC'D BY REGISTRAR <b>NOV 28 1958</b>		24b. REGISTRAR'S SIGNATURE <b>11-28-58</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12770

12772

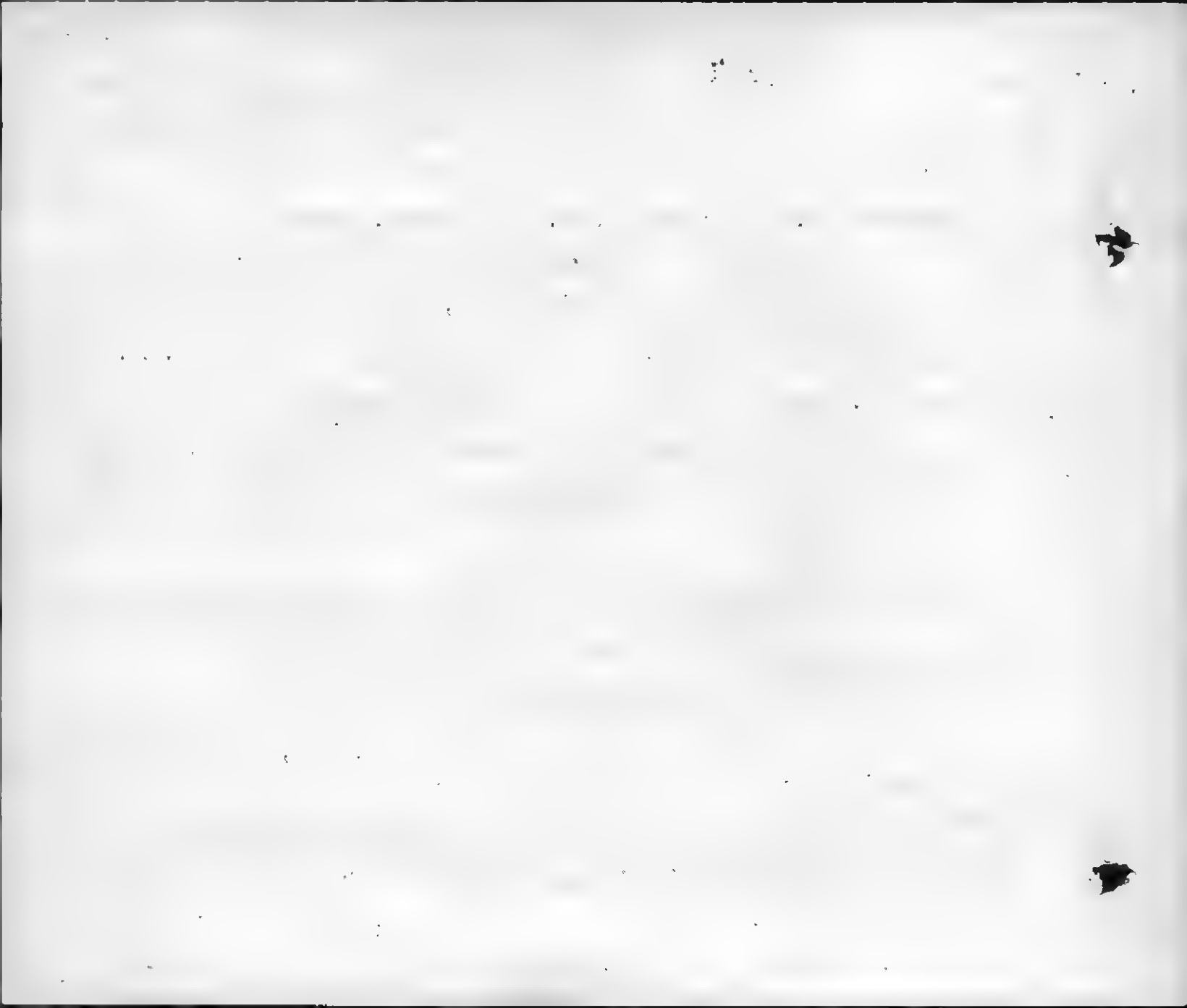
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>			
c. LENGTH OF STAY IN 1b <b>133 days</b>				d. STREET ADDRESS <b>4013 No. Chesterbrook Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>David</b>		First <b>Sargeant</b>		Middle <b>Swanson</b>		Last	
4. DATE OF DEATH Month <b>November</b>		Day <b>10,</b>		Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1943</b>	9. AGE (In years last birthday) <b>15</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Chandler W. Swanson</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Sarge ant</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMOPERICARDIUM secondary to</b> <b>178X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Embryonal rhabdomyosarcoma of left testis with</b> DUE TO <b>widespread metastasis.</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 28, 19 58</b> , to <b>November 10, 19 58</b> , that I last saw the deceased alive on <b>November 10, 19 58</b> , and that death occurred at <b>9:07 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>11-10-58</b> ACTUAL SIGNATURE <b>Peter S. Mueller, M.D.</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Mueller, Peter S., M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 13 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12773

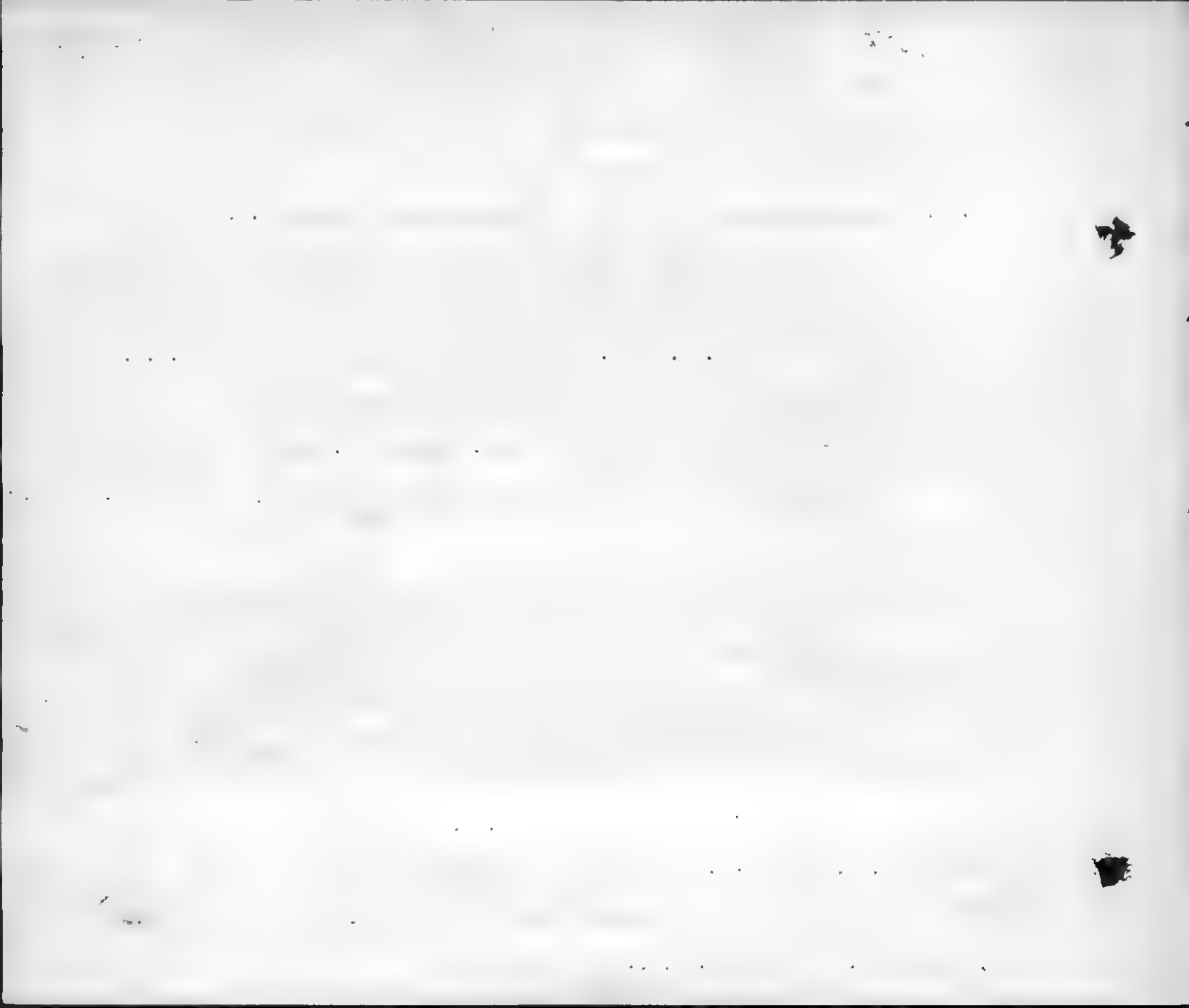
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

12771

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>16 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Washington</b> d. STREET ADDRESS <b>5120 Klinge Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Byron Edward Richard TAYLOR</b>		4. DATE OF DEATH Month Day Year <b>November 12 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-14</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cartographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Byron Edward TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>Helen Gertrude ASH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 3/36 - 2/46</b>		16. SOCIAL SECURITY NO. <b>578-38-4824</b>	
17. INFORMANT Address <b>(W) Mrs. Marjorie G. Taylor, same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Appr. 6 mos.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 27, 1958</b> , to <b>November 12, 1958</b> , that I last saw the deceased alive on <b>November 11, 1958</b> , and that death occurred at <b>1:12A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>AT Thorp Jr.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NNM 11-12-58</b>	
PHYSICIAN'S NAME (Type) <b>A. T. THORP, JR.</b>		<b>Bethesda 14, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-14-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers, 3072 "M" St., N.W., Washington, DC</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 13 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12774

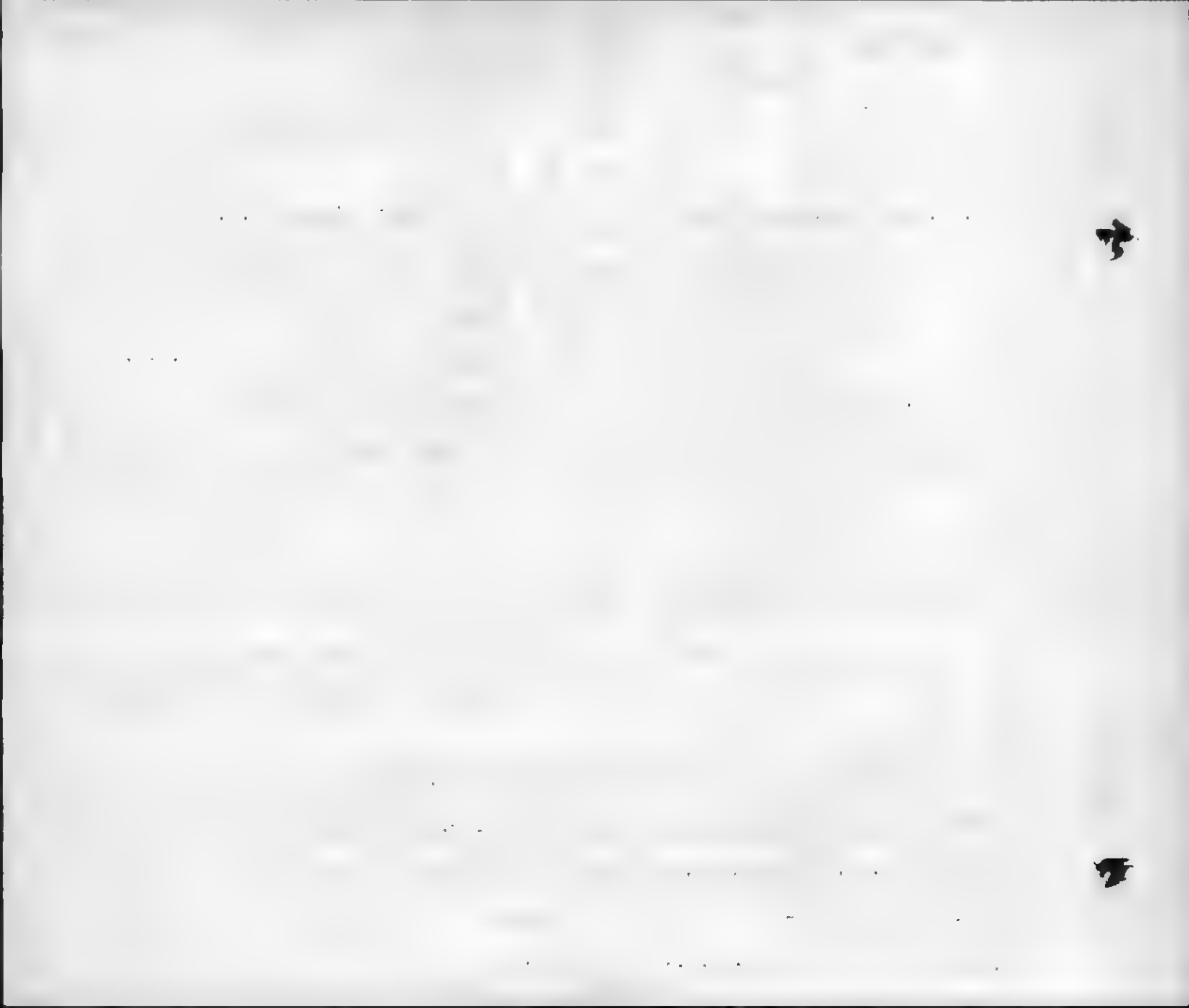
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12772

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>7 hours</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1650 Harvard Street, N.W.</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>THARP</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-58</b>
9. AGE (in years last birthday) yrs <b>7</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joel E. THARP</b>		14. MOTHER'S MAIDEN NAME <b>Carmen Dolores WAGGNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Official Navy Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>776x</b> <b>Pneumonia - immaturity (&lt;1000 G.)</b> DUE TO (b) <b>7 hrs</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 17, 1958</b> , to <b>November 17, 1958</b> , that I last saw the deceased alive on <b>November 17, 1958</b> , and that death occurred at <b>11:45 P. M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>11-17-58</b>			
ACTUAL SIGNATURE <b>Howard A. Pearson</b>		PHYSICIAN'S NAME (Type) <b>H. A. PEARSON, LT, MC, USN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-21-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b>		24a. REC'D BY REGISTRAR <b>NOV 21 '58</b>	
ADDRESS <b>2901 14th St., N.W., Washington, DC</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Hines</b>	



1  
FOR STATE  
HEALTH DEPT.

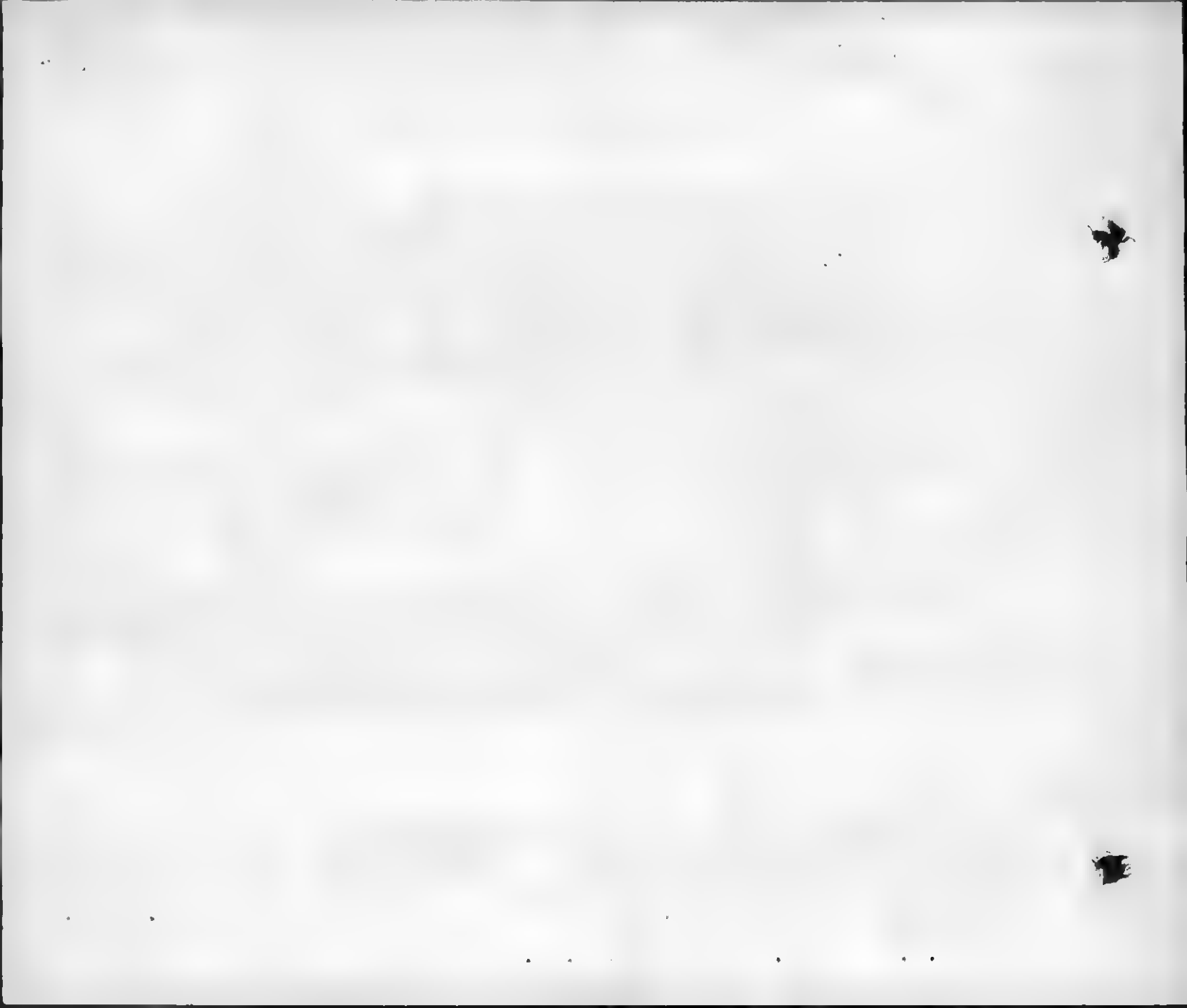
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12773

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2509 Randolph Rd</u>				e. STREET ADDRESS <u>2509 Randolph Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Ruth Hall Todd</u>				4. DATE OF DEATH <u>11-17-58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		11. BIRTHPLACE (State or foreign country) <u>Ark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wells Todd</u>				14. MOTHER'S MAIDEN NAME <u>Caroline E. Chester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>JoAnna Berry</u>			
17. INFORMANT <u>Same</u>				Address <u>Room 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-17-58</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>11/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S.H.Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>Nov 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Andrew S. Hines</u>	

TO THE MEDICAL EXAMINER: This certificate should be filed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12619

## CERTIFICATE OF DEATH

Reg. Dist. No. 12774

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> <u>12 X 2</u>	
c. LENGTH OF STAY IN 1b <u>DOA.</u>		d. STREET ADDRESS <u>Washington Sanitarium / bsp. 2214 Phelps Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gina</u> First <u>MICHELLE</u> Middle <u>Tunman</u> Last	4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-58</u>
9. AGE (In years last birthday) yrs <u>22</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>9</u> Days <u>22</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest O. Tunman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret M. Schoemig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mother + Father</u>		Address <u>Adelphi, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lungo-tracheo-bronchitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute infection</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx one hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of stem 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>9:00 PM 11/18/58</u> to <u>10:00 PM 11/18/58</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>58</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Murray Paul</u> M.D.		ADDRESS (Street, city or town, state) <u>8106 New Hampshire Ave Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>MURRAY PAUL, M.D.</u>		DATE SIGNED <u>11/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond R. Huska</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>NOV 21 58</u>	24b. REGISTRAR'S SIGNATURE <u></u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart has been notified  
& permission received to sign  
certificate

Murray Paul, M.D. ✱  
J.W.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12775

f. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN fb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Atwood Road</u>		• IS KEPT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harvey R. Turner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1899</u>	9. AGE (In years last birthday) <u>59</u> yrs	10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Country Club</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Turner</u>		14. MOTHER'S MAIDEN NAME <u>May Brown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Mrs. Florence Turner</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>10:10</u> a.m. <u>11/11/58</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>Nov. 8, 1958</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>BURTONSVILLE, MONTGOMERY CO., MD.</u>		22e. (State) <u>  </u>		22f. (City, town, or county) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WAPNER E. POMPHELY, INC., Silver Spring, Md.</u> <u>Raymond A. Giska</u>		ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		24c. (City, town, or county) <u>  </u>		24d. (State) <u>  </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Baltimore, MD 12777										STATE OF HEALTH—BALTIMORE, 18 12777										Reg. Dist. No. 12776									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>																			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>										d. STREET ADDRESS <u>2704 Urbana Ave.</u>																			
3. NAME OF DECEASED (Type or print) <u>JON</u> First <u>BARBARA</u> Middle <u>BARBARA</u> Last <u>VASBINDER</u>										4. DATE OF DEATH <u>NOVEMBER 13</u> 19 <u>58</u>																			
5. SEX <u>MALE</u>										6. COLOR OR RACE <u>White</u>																			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH <u>NOVEMBER 13 1954</u>																			
9. AGE (In years last birthday) <u>4</u> yrs.										10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min <u>1</u> <u>45</u>																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY																			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>										12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																			
13. FATHER'S NAME <u>JAMES WILLIAM VASBINDER</u>										14. MOTHER'S MAIDEN NAME <u>DAISY MARIE SIMON</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)										16. SOCIAL SECURITY NO. <u>—</u>																			
17. INFORMANT <u>FATHER</u> Address <u>Item #2</u>																													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>From a Tumor (6th month)</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from <u>11/13</u> , 19 <u>58</u> , to <u>11/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/13</u> , 19 <u>58</u> , and that death occurred at <u>10:10</u> P. M., from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>Kensington, Md.</u> DATE SIGNED <u>11/14/58</u>																			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.																													
PHYSICIAN'S NAME (Type) <u>Kensington, Maryland</u>																													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>										22b. DATE THEREOF <u>11/15/58</u>																			
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>										22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>																			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>										24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>																			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

12777

Item 18 Film 237 1-13-59 ams

12778

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>N. J.</b> b. COUNTY <b>BURLINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHARTER CHASE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOORESTOWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6810 BROOKVILLE RD.</b>				d. STREET ADDRESS <b>R.D. # 5</b>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>WALTON</b> Last <b>NOV</b>				4. DATE OF DEATH Month <b>NOV</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 15, 1903</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROFESSOR OF SOCIAL SERVICE TEACHER</b>		11. BIRTHPLACE (State or foreign country) <b>N. J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>SILAS WALTON</b>				14. MOTHER'S MAIDEN NAME <b>MARY BROOKS JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <b>Joseph L. Walton - 6810 Brookville Rd. Cherry Chase Md.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>153.8</b> DUE TO Ca of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 year</b> (c) <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>September 1958</b> , to <b>Nov. 28</b> , 1958, that I last saw the deceased alive on <b>Nov 26</b> , 1958, and that death occurred at <b>3:25 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Irene G. Tamagna</b> M.D. <b>7101 CONN. AVE. Ch. G. Md.</b>							
PHYSICIAN'S NAME (Type) <b>IRENE G TAMAGNA</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>CREMATION</b>		<b>11-29-58</b>		<b>Lees Cemetery</b>		<b>Wash. D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lees</b>				ADDRESS <b>Wash. D. C.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. S. H. H. H.</b>	
24a. REC'D BY REGISTRAR <b>DEC 2 1958</b>							





FOR STATE  
HEALTH DEPT.

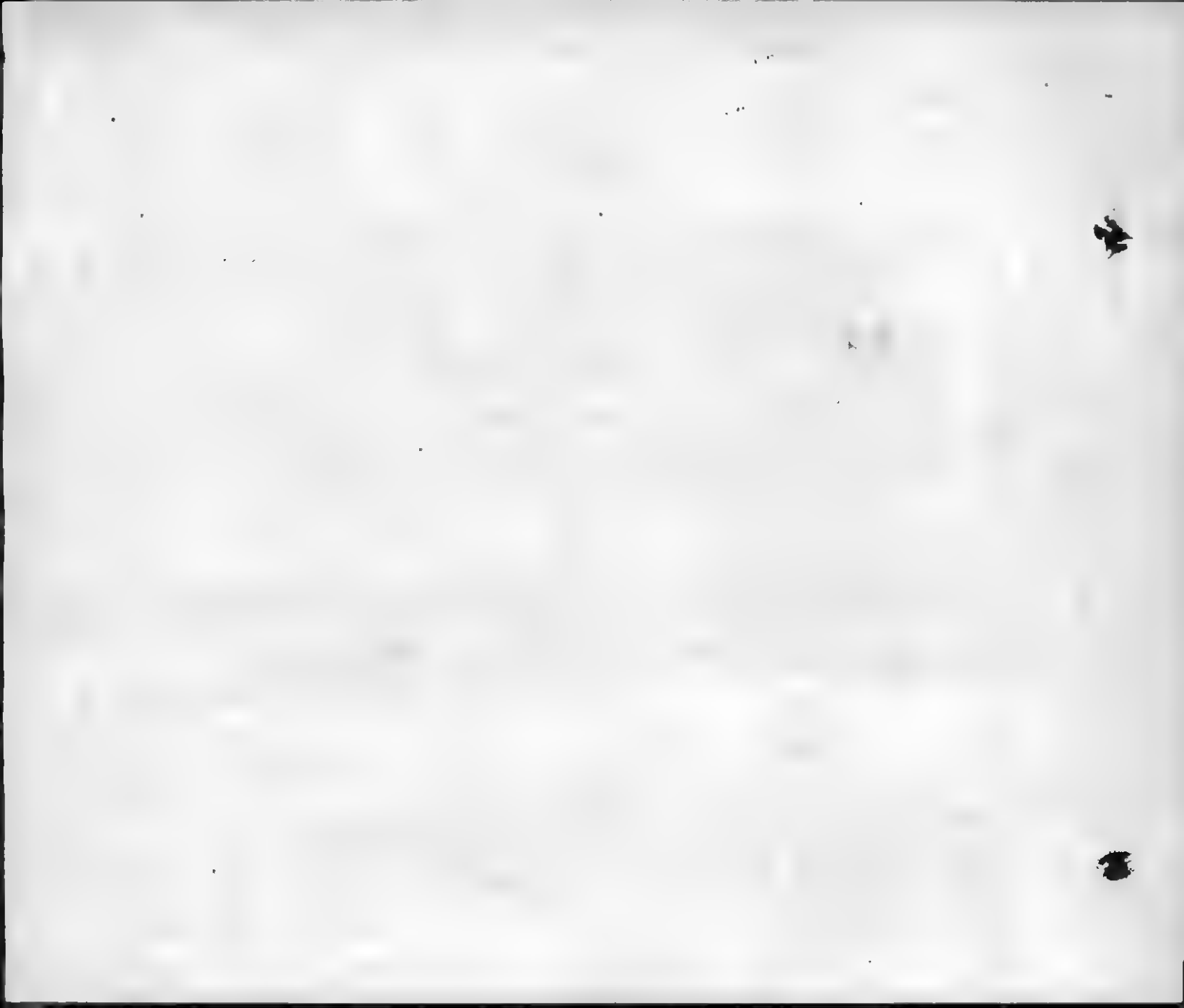
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>6 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3605 Chevy Chase Lake Dr.</b>		e. STREET ADDRESS <b>3605 Chevy Chase Lake Dr.</b>	
3. NAME OF DECEASED (Type or print) <b>Desmond Joseph Ward</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/1904</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 24 HRS: Months <b>1</b> Days <b>5</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>realtor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph S. Ward</b>		14. MOTHER'S MAIDEN NAME <b>? Garity</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes After WWI</b>		16. SOCIAL SECURITY NO <b>212-24-4451</b>	
17. INFORMANT <b>Frances D. Ward (wife)</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (c), stating the underlying cause last. (c) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II at item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>Nov. 4, 1958</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/7/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Nov 6 '58</b>			

1. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please  
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12620

12779

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>46815 Red Top Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>None</u> Last <u>Weiner</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>16</u> - Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-77</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Manufacturer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u> ✓	
13. FATHER'S NAME <u>Jacob Weiner</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium &amp; Hospital/Reed</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>October 26, 1958</u> to <u>November 16, 1958</u> , that I last saw the deceased alive on <u>November 13, 1958</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabkin</u>				M.D. <u>1019 University Boulevard</u>		DATE SIGNED <u>11/16/58</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>				<u>Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Adath Yeshurun Cem.</u>		22d. LOCATION (City, town or county) (State) <u>Montreal, Canada</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Danyusky &amp; Sons</u>				ADDRESS <u>3506-14th St N.W.</u>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 18 '58

C. H. - P. K. W. A.



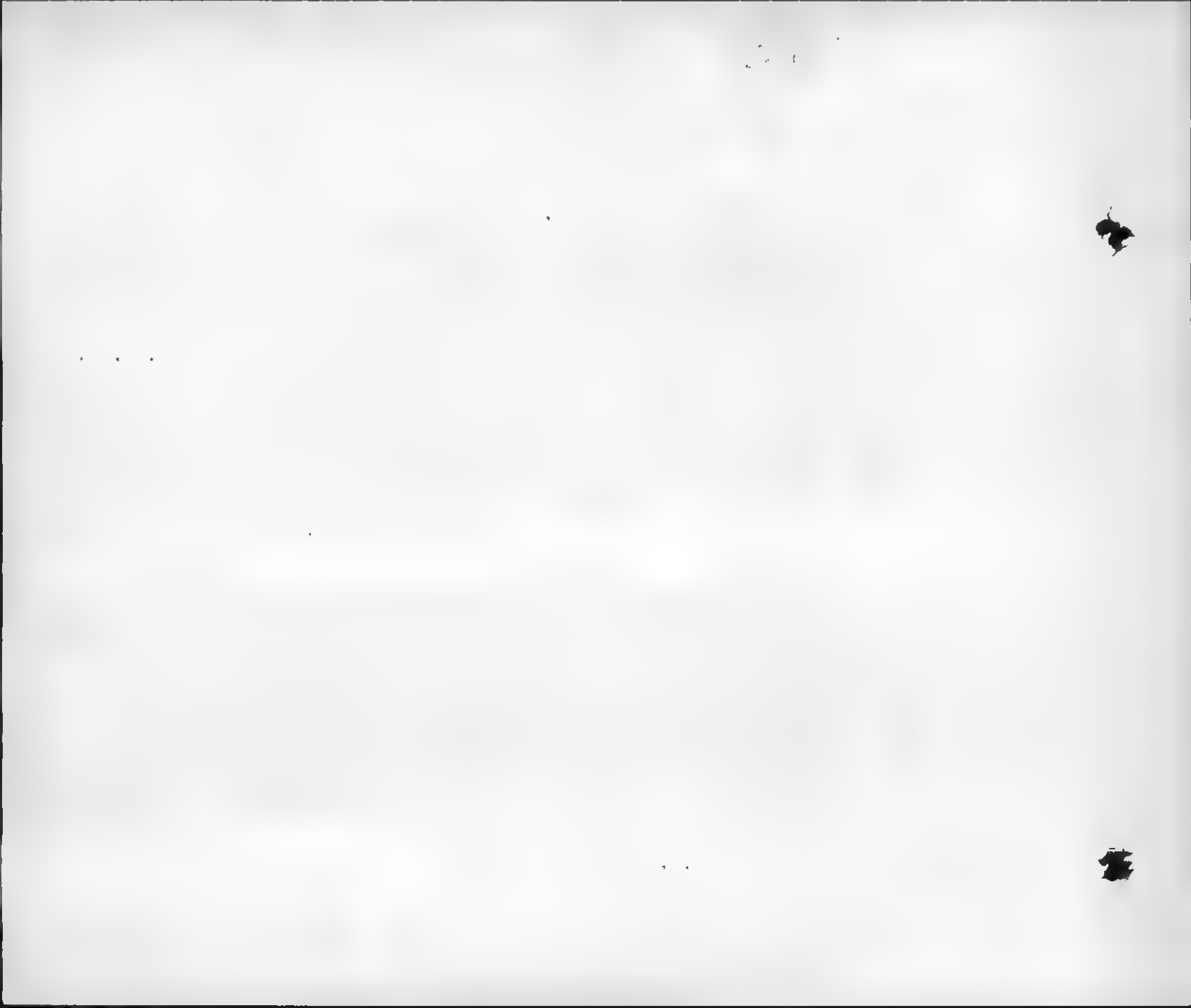
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12780**  
**CERTIFICATE OF DEATH**

**12780**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>92 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>3501 Northridge Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Freda</u> Last <u>Weiss</u>				4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1908</u>	
9. AGE (In years last birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Samuel Collector</u>				14. MOTHER'S MAIDEN NAME <u>Leah Berkowich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>0001</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bronchopneumonia and Hepato Splenomegaly</u> DUE TO (c) <u>Staphylococcal Infection</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subacute Cerebral Degeneration of Heidenhain</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 2, 1958</u> to <u>November 2, 1958</u> , that I last saw the deceased alive on <u>November 2, 1958</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Bushnell Smith MD</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>11/3/58</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>BUSHNELL SMITH, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc - 2100 Eilow Place</u>				ADDRESS <u>Balto. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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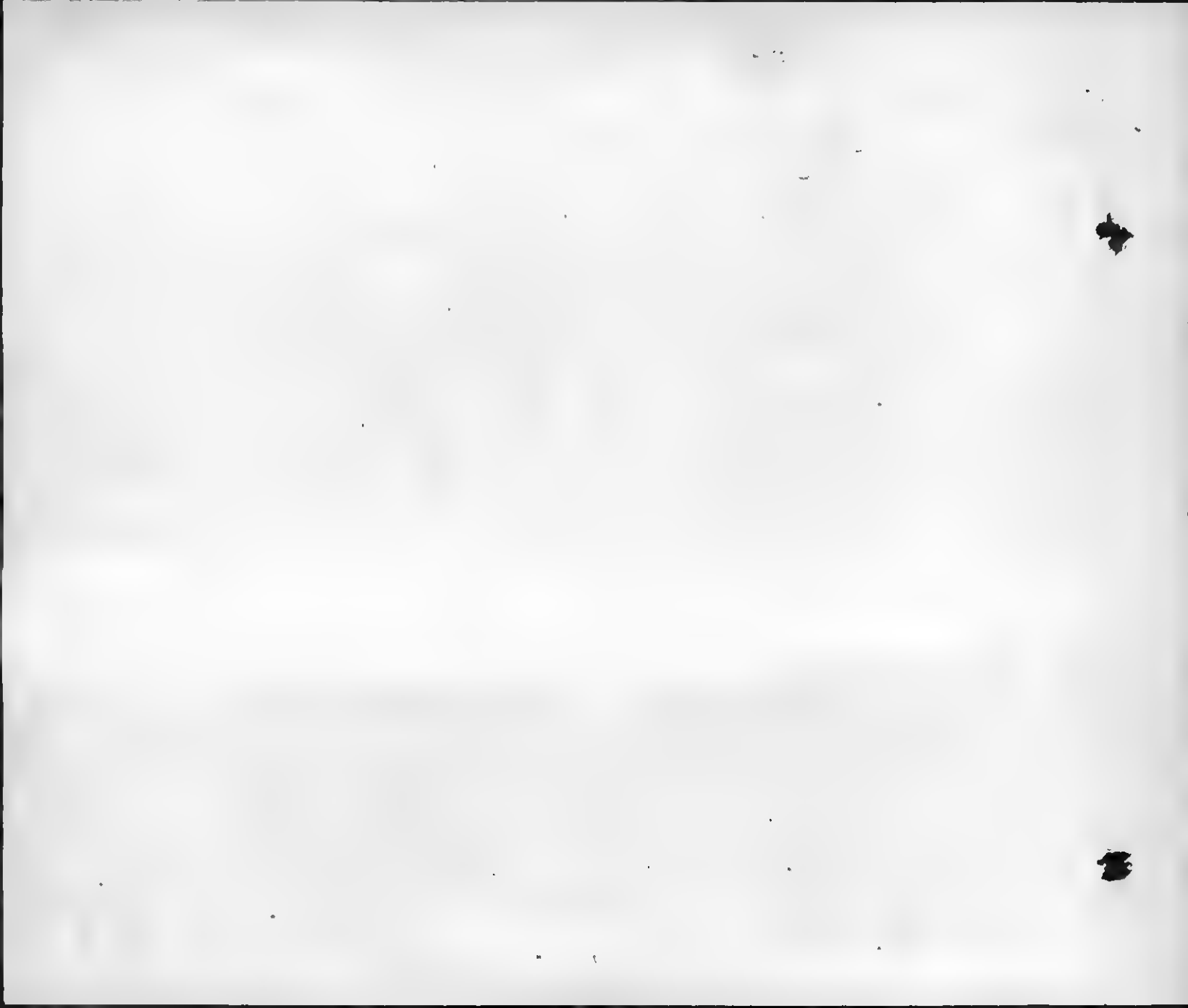
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>Chattanooga</b>	
c. LENGTH OF STAY IN 1b <b>62 days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chattanooga</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>801 Rockway Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Nell</b> Last <b>White</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1931</b>
9. AGE (In years last birthday) <b>27 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Raymond L. Sims</b>		14. MOTHER'S MAIDEN NAME <b>Eula Hulsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>118-24-1779</b>	
17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest in postoperative period</b> <b>410x</b> DUE TO <b>Prolonged hypotension postoperatively</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypotension due to anesthetic insufficiency + atelectasis + aortic insufficiency</b> DUE TO <b>Pneumothorax</b> (c) <b>Coronary artery disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>September 21, 19 58</b> to <b>November 22, 19 58</b> , that I last saw the deceased alive on <b>November 22, 19 58</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b> DATE SIGNED <b>11-23-58</b>			
ACTUAL SIGNATURE <b>William P. Cornell</b>		M.D. <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>William P. Cornell, M.D.</b>		<b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL CREMATION <b>Burial-transit</b>	22b. DATE THEREOF <b>11-23-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fuller Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>DeKalb Co., Ga., Alabama</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 26 1958</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. S. Pumphrey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.





12782

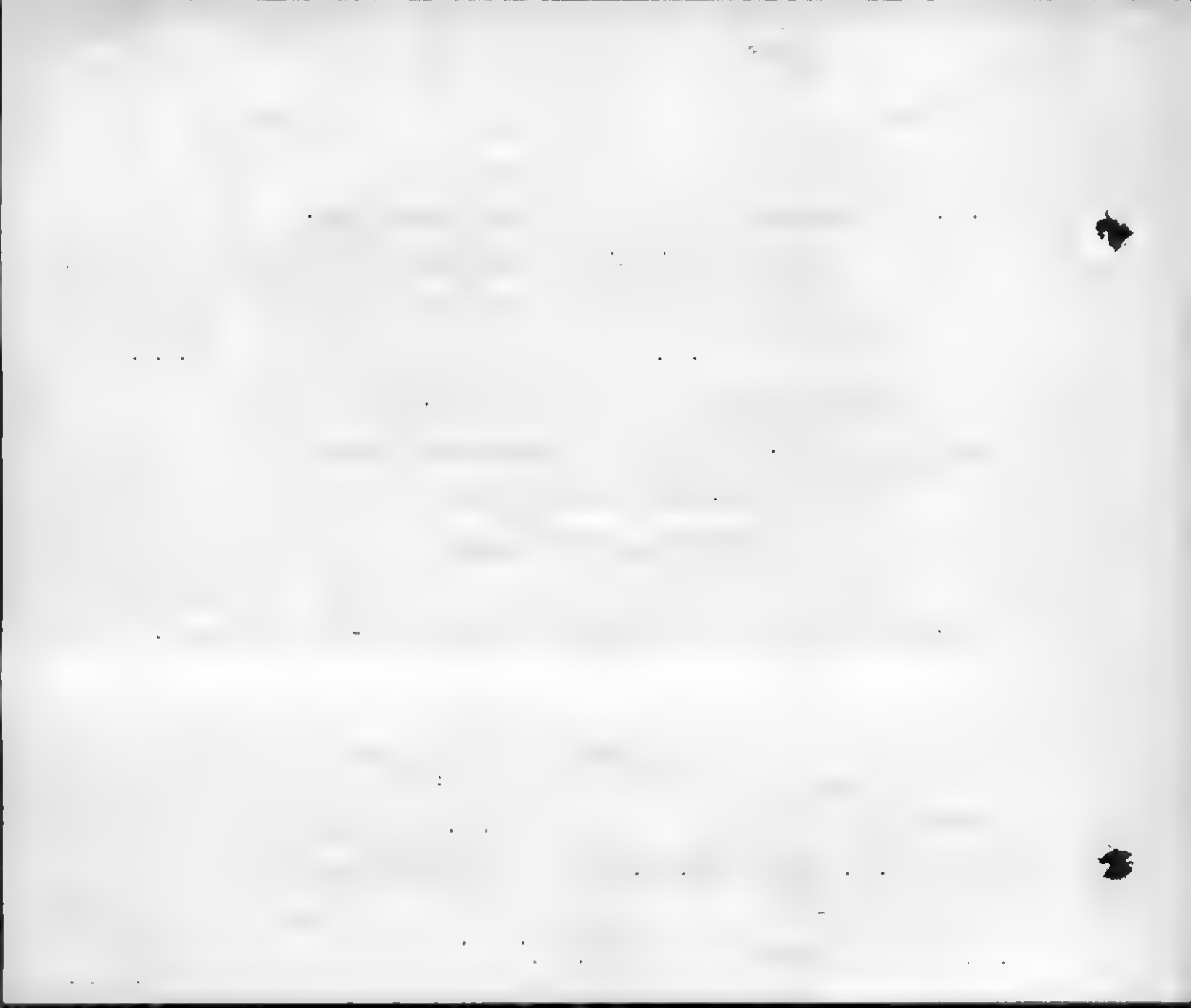
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>20 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>6300 Wisconsin Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grady Baskin WHITEHEAD</b>		4. DATE OF DEATH Month Day Year <b>November 1 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-20-89</b>
9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months Days Hours M n	11. IF UNDER 24 HRS Months Days Hours M n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Beeland WHITEHEAD</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. SPIVEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WWI - WWII</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Official Navy Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Ruptured abdominal aneurysm</b> <b>431X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Bleeding diathesis due to autogenous circulating anti-coagulant - 6mos.</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 12</b> , 19 <b>58</b> , to <b>November 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>October 31</b> , 19 <b>58</b> , and that death occurred at <b>4:30A</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NMMC 11-1-58</b>			
ACTUAL SIGNATURE <b>J. T. Horgan</b>		M. D. <b>U. S. Naval Hospital, NMMC</b>	
NAME (Type) <b>J. T. HORGAN, LCDR, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-4-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Horgan</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

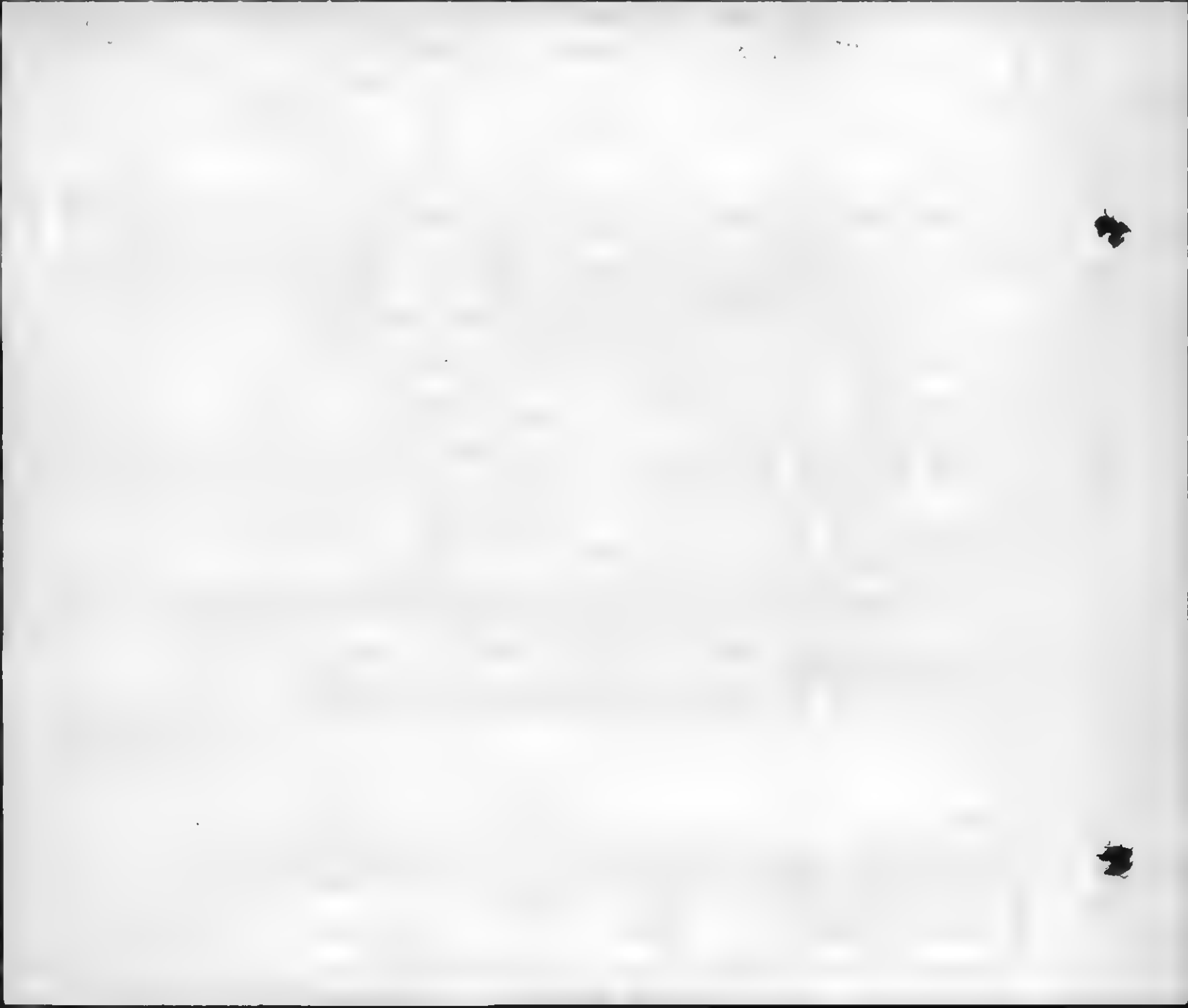


12783 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12783 CERTIFICATE OF DEATH

12783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Nursing Home</u>				d. STREET ADDRESS <u>3411 Oakwood Ln. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>EDSON</u> First <u>LEONE</u> Middle <u>WHITNEY</u> Last				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-61</u>	9. AGE (In years last birthday) <u>97</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Translator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fredrick Whitney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Marion</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clifford Whitney</u> <u>3411 Oakwood Ln. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 6</u> , 19 <u>57</u> , to <u>NOV. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>NOV. 26</u> , 19 <u>58</u> , and that death occurred at <u>10:02 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.				ADDRESS (Street, city or town, state) <u>5206 Newway Dr.</u>		DATE SIGNED <u>11/26/58</u>	
PHYSICIAN'S NAME (Type) <u>Henry M. Lowden</u>				<u>Cherry Chase, Ind.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crestal Lake Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Stadman Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers &amp; Co Inc</u>				ADDRESS <u>1400 Chapin St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



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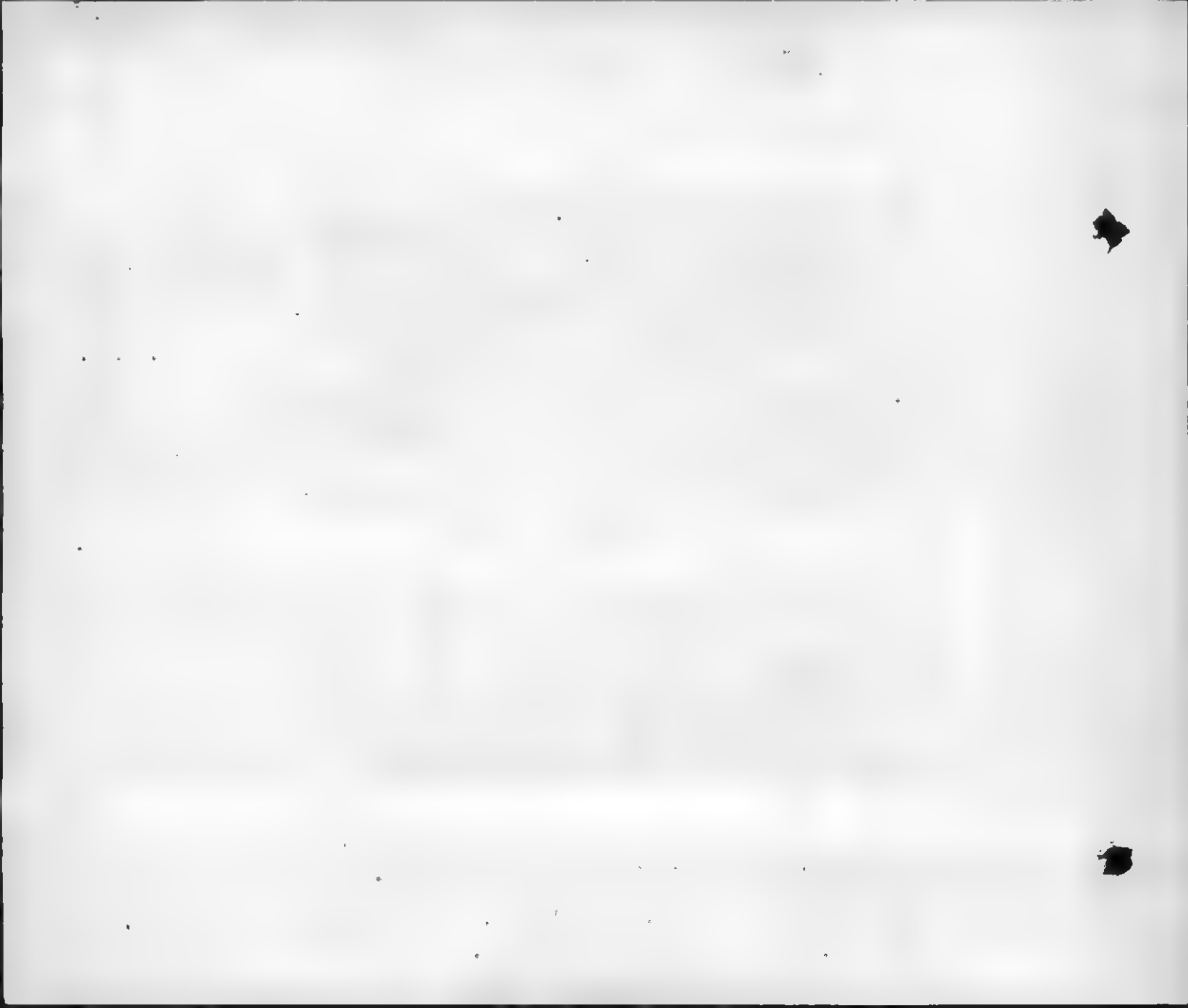
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>63 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Lancaster</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. STREET ADDRESS <b>234 Ruby Street</b> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Eugene Wiegand</b>		4. DATE OF DEATH Month Day Year <b>November 11, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1953</b>
9. AGE (In years last birthday) <b>5 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Peter F. Wiegand</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Stockbauer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcal Pneumonia and Septicemia</b> <b>03.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Lymphocytic Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>mos.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 9, 1958</b> , to <b>November 11, 1958</b> , that I last saw the deceased alive on <b>November 11, 1958</b> , and that death occurred at <b>1:05 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>11-11-58</b> ACTUAL SIGNATURE <b>Robert J. Schwab, M.D.</b> PHYSICIAN'S NAME (Type) <b>Paul J. Schwab, M. D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		22b. DATE THEREOF <b>11/14/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cem. (New)</b>		22d. LOCATION (City, town or county) (State) <b>Lancaster, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>James S. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12785

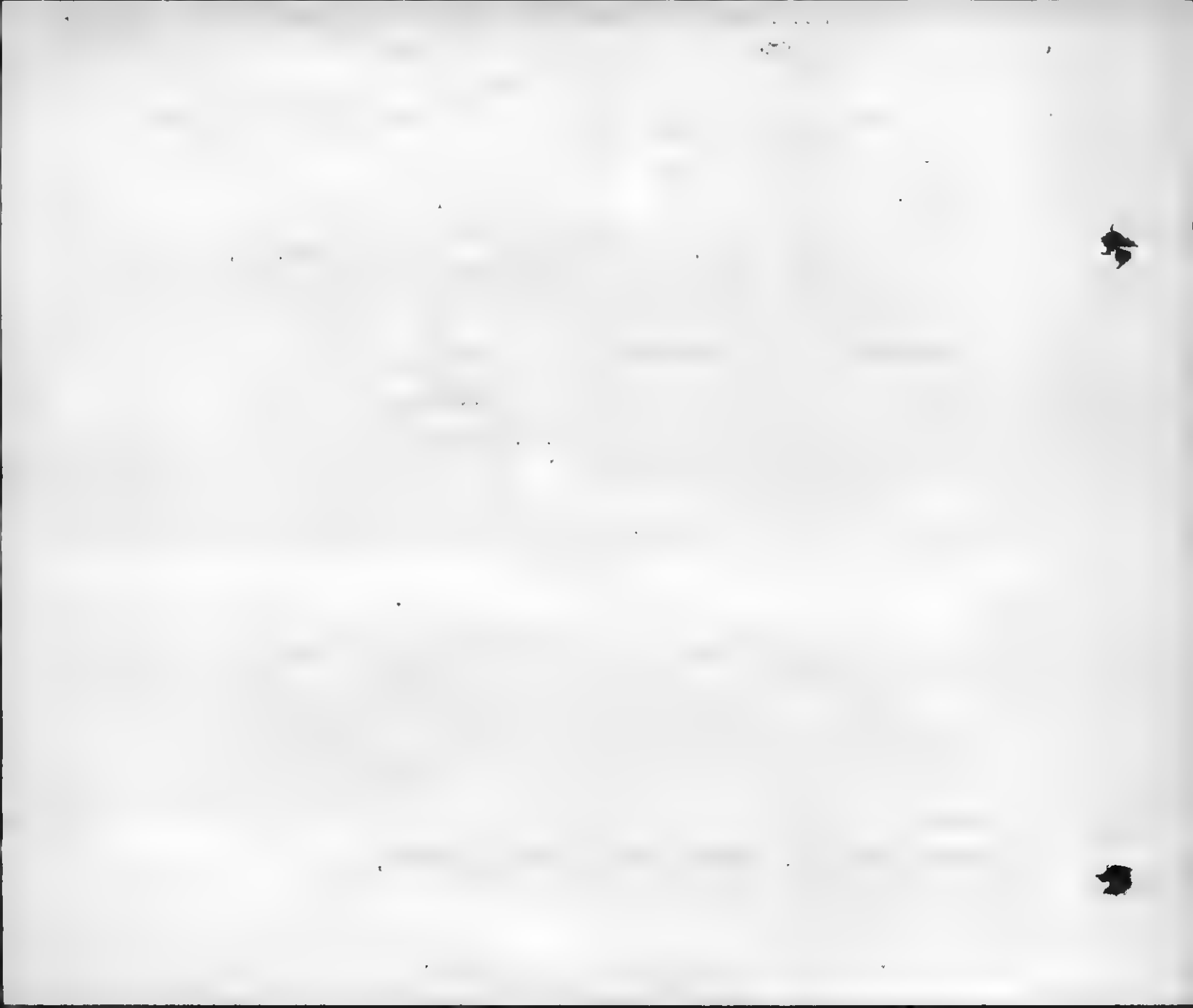
12785

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>Chevy Chase</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>25 Hesketh Street</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>25 Hesketh Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>MAUDE L. WILLIS</b> First Middle Last		4 DATE OF DEATH <b>Nov. 29, 1958</b> Month Day Year	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 15, 1870</b>
9 AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b>	IF UNDER 24 HRS Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Texas</b>		12 CITIZEN OF WHAT COUNTRY? <b>US</b>	
13 FATHER'S NAME <b>Unknown</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>	
17 INFORMANT <b>W. F. Cross-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 331x DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1956</b> to <b>Present</b> , 1958, that I last saw the deceased alive on <b>11/10</b> , 1958, and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald Q. Ekman</b> M. D. <b>5707 Wisconsin Ave</b>		DATE SIGNED <b>11/29/58</b>	
PHYSICIAN'S NAME (Type) <b>Donald Q. Ekman 5707 Wisconsin Avenue,</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>12/3/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Uniontown</b>	22d. LOCATION (City, town, or county) (State) <b>Uniontown, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Cross</b>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1529 Beall Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Leon</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/4/92</u>	
9. AGE (In years last birthdys) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Navystad</u>		11. BIRTH PLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>un known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>217-36-5813</u>		17. INFORMANT Address <u>Cornelia Willis - same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain tumor (glioma), involving frontal pole</u> DUE TO <u>polo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, bilateral, involving both lower lobes</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Nov. 5</u> , 1958, to <u>Nov. 16</u> , 1958, that I last saw the deceased alive on <u>Nov. 15</u> , 1958, and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave, Bethesda, Md</u> DATE SIGNED <u>11/16/58</u> ACTUAL SIGNATURE <u>Robert G. Angle</u> PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DA NOV 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.



12787

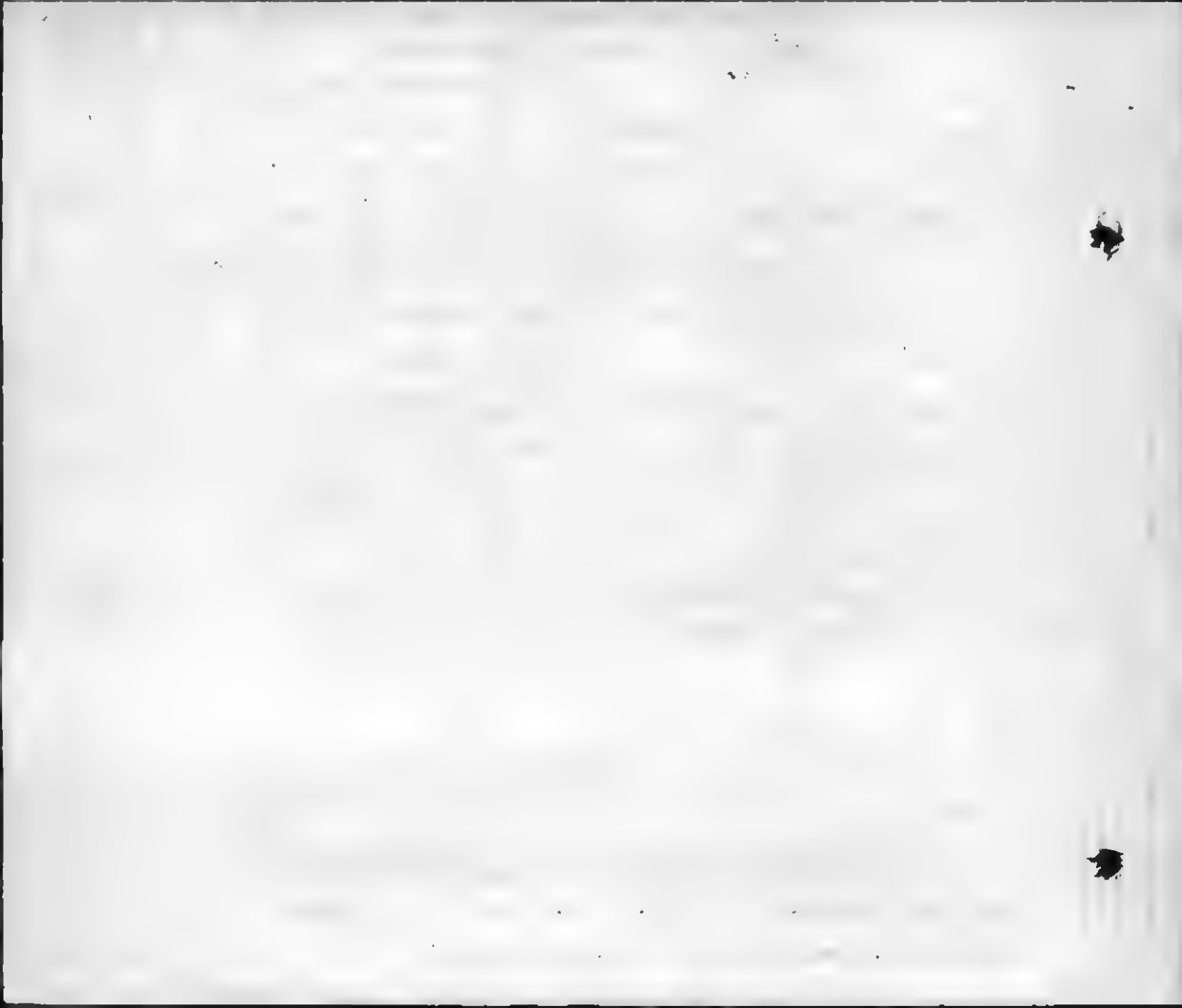
## CERTIFICATE OF DEATH

12787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10/30/58</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>28 10020 River Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>[REDACTED]</u> Last <u>Windsor</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/30</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture Dept</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOSEPH WINDSOR</u>		14. MOTHER'S MAIDEN NAME <u>? CAROLL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dorothy E. Hunter - Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia, R. L. lobe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis, generalized c ASHD and renal impairment</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>58</u> , to <u>Nov 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 2</u> , 19 <u>58</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <u>Earl H. Mitchell</u> M.D. <u>2029 Q ST. N.W.</u>					
PHYSICIAN'S NAME (Type) <u>EARL H. MITCHELL WASHINGTON D.C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pot. Meth. Church</u>	22d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 9-5-11-23, 11-14-58 et

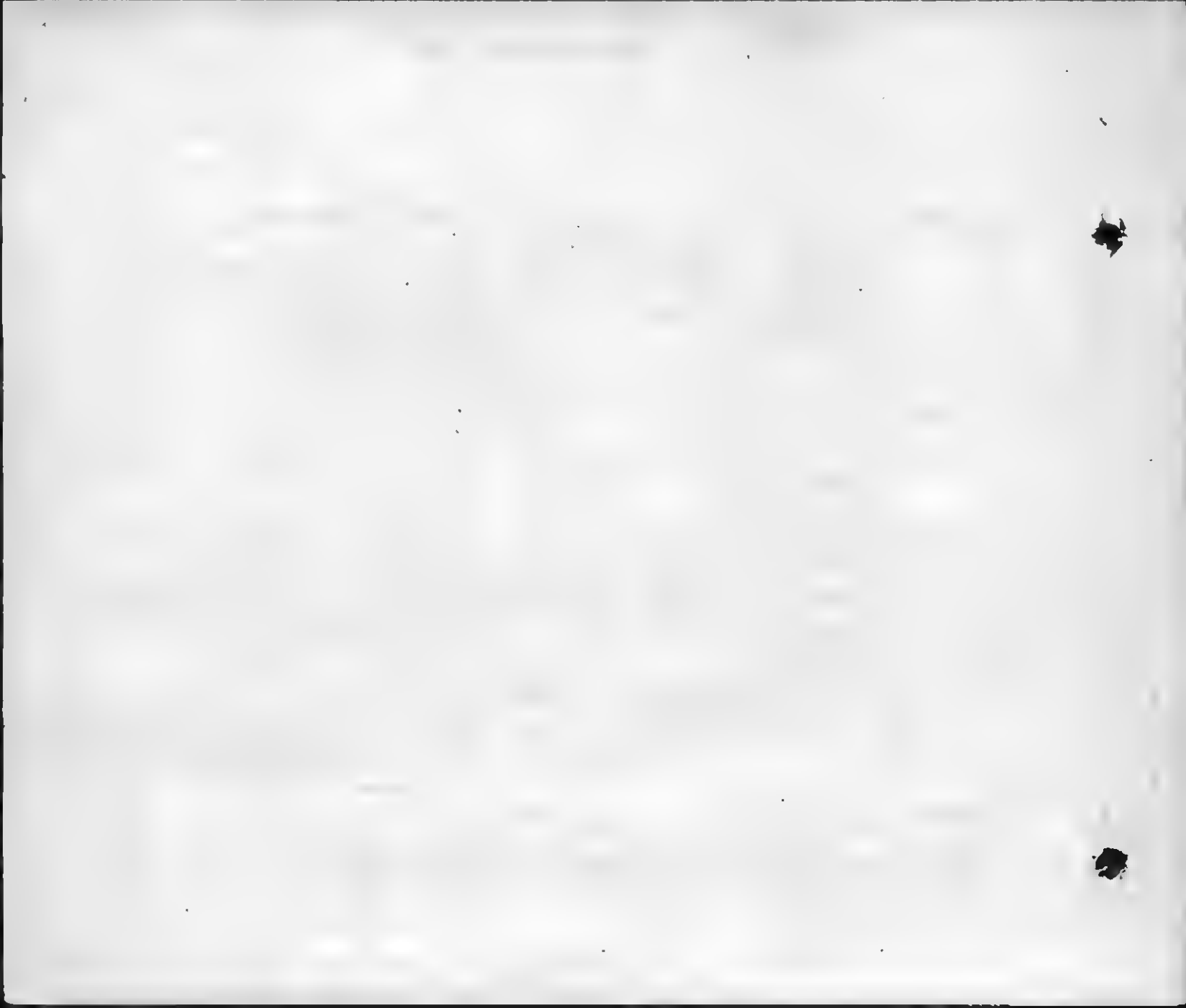
12788

# CERTIFICATE OF DEATH

12788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co - Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery - Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Cherry Chase - Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3806 Williams Lane</u>		d. STREET ADDRESS <u>3806 Williams Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Theodora</u> First <u>Marianne</u> Middle <u>Wigman</u> Last <u>Booth</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24 - 1868</u>
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u>	IF UNDER 24 HRS Hours <u>16</u> Min <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Toronto, Canada.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wood Booth</u>		14. MOTHER'S MAIDEN NAME <u>Clara Louise Irene Gagnier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Edith W. Masters</u>		Address <u>3806 Williams Lane Cherry Chase - Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestion of heart failure and</u> DUE TO (c) <u>myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 1951, to <u>10 Nov</u> , 1958, that I last saw the deceased alive on <u>10 Nov</u> , 1958, and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u> M.D.		<u>5029 BETHESDA AVE</u> <u>10 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR.</u>		<u>BETHESDA, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Nov 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Selling S. Kins</u>	



12789

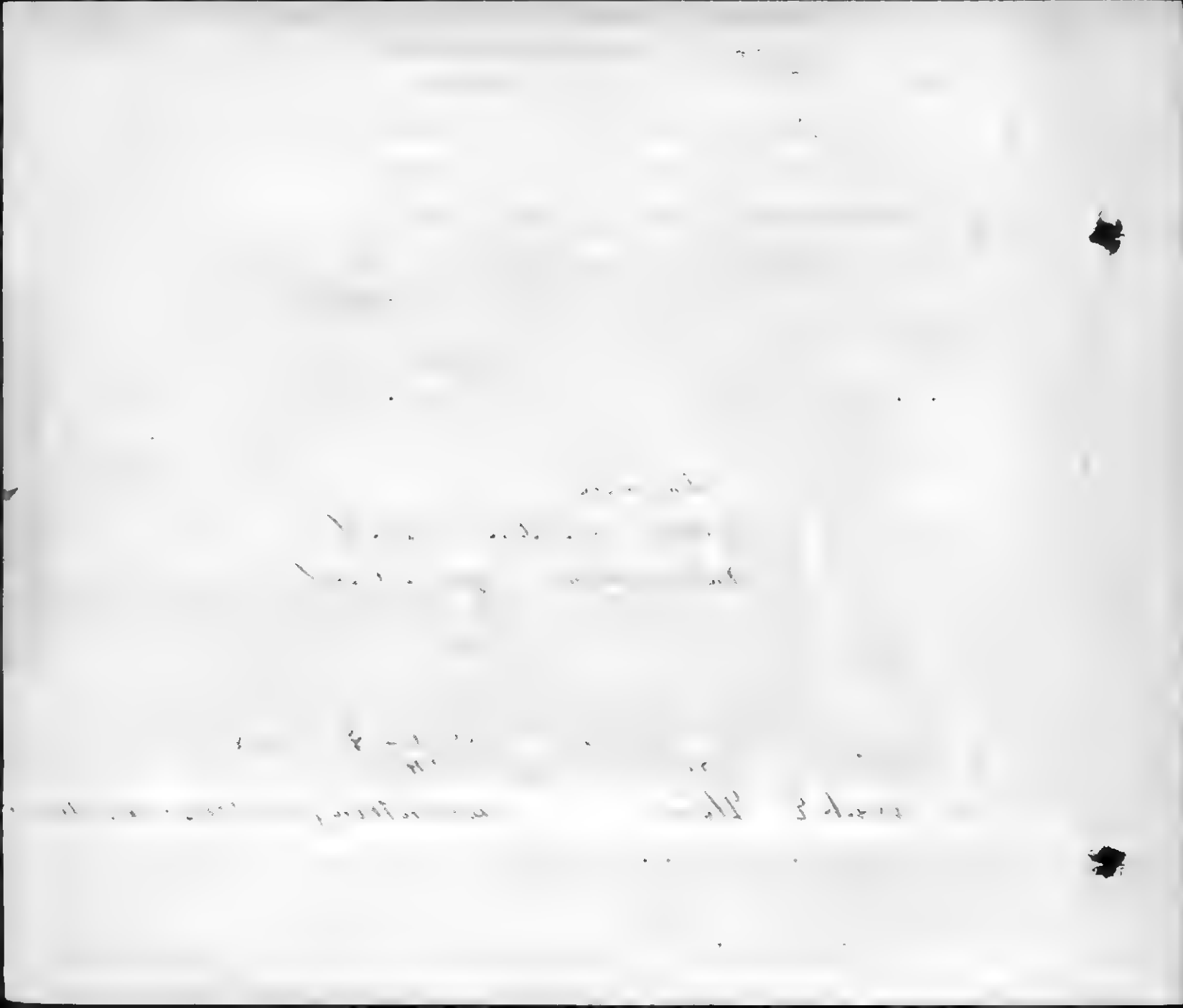
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Orlando</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orlando</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E</b> Last <b>Woodford</b>				4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 15, 1872</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Queen Ann Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>E. B. Van Dyke</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Shawm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Asbury Methodist Home Records, Gaithersburg</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unk</b> DUE TO <b>IX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cerebral vascular accident</b> (c) <b>Arteriosclerosis generalized</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12-25</b> , 19 <b>58</b> , to <b>11-9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-8</b> , 19 <b>58</b> , and that death occurred at <b>9:4</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Sarah E. Glover</b> M.D. <b>4208 Anthony St Kensington, Md 11-9-58</b> PHYSICIAN'S NAME (Type) <b>Sarah E. Glover, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11-12-58</b>		<b>Centerville</b>		<b>Centerville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Carl G. Shaw</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





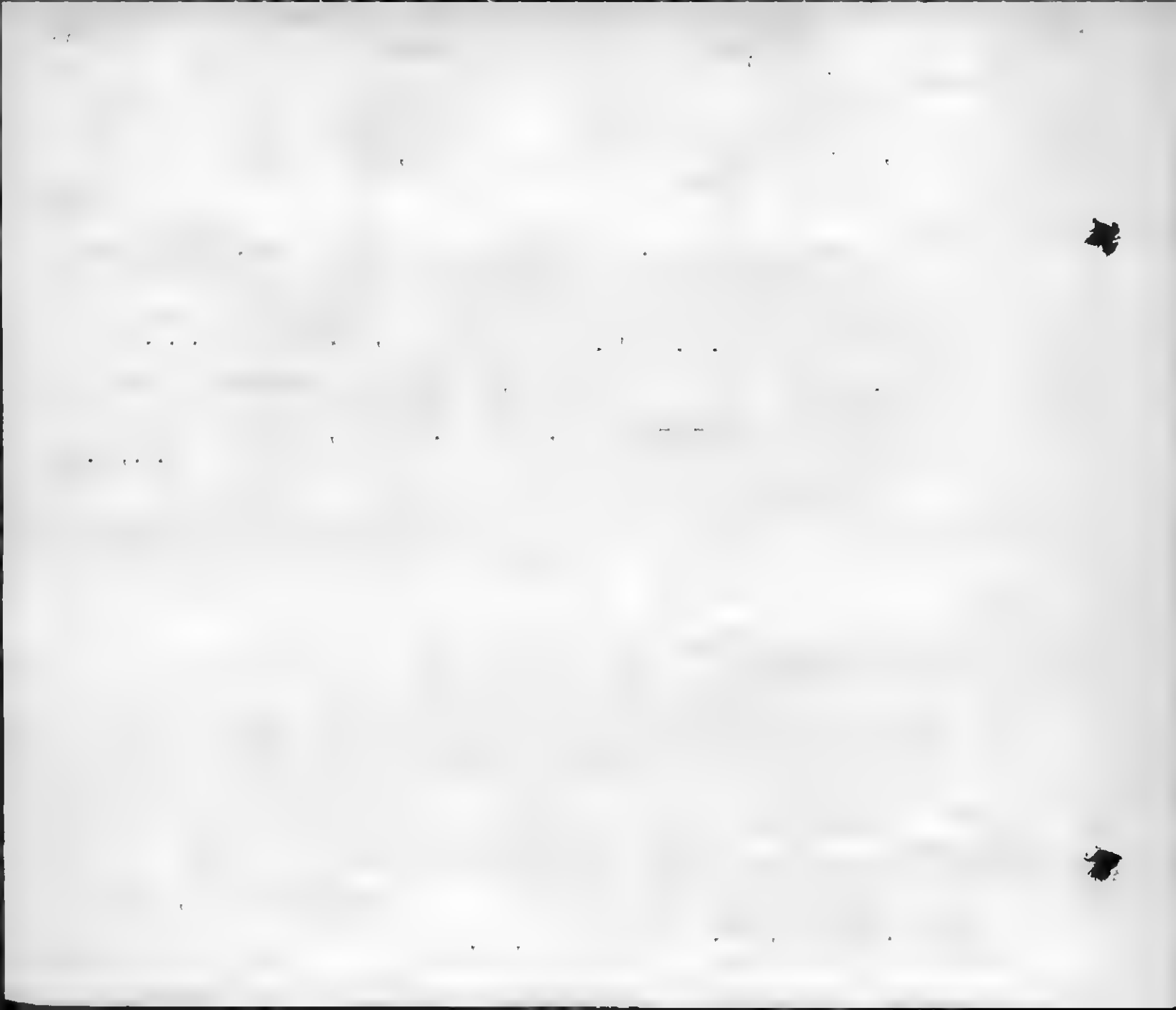
12790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville, Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>8 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville, Silver Spring</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>706 Orchard Way</b>			
d. STREET ADDRESS <b>706 Orchard Way</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOLA</b> Middle <b>H.</b> Last <b>WOOTTON</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>29</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/23/11</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>Prosperity, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William J. Haddock</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Martha <del>Winkler</del> CREWSE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>578-14-4181</b>		17. INFORMANT <b>Mr. Norman D. Wootton, 706 Orchard Way</b>	
				<b>Colesville, S. S. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>April 19 1956</b> to <b>Nov. 24 1958</b> , that I last saw the deceased alive on <b>Nov. 29 1958</b> , and that death occurred at <b>4:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9241 Col. Blvd. Silver Spring, Md.</b> DATE SIGNED <b>Nov 29, 1958</b>							
ACTUAL SIGNATURE <b>Marion B. Bland</b>							
PHYSICIAN'S NAME (Type) <b>J. Marion Bland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MONOCACY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 4 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12791

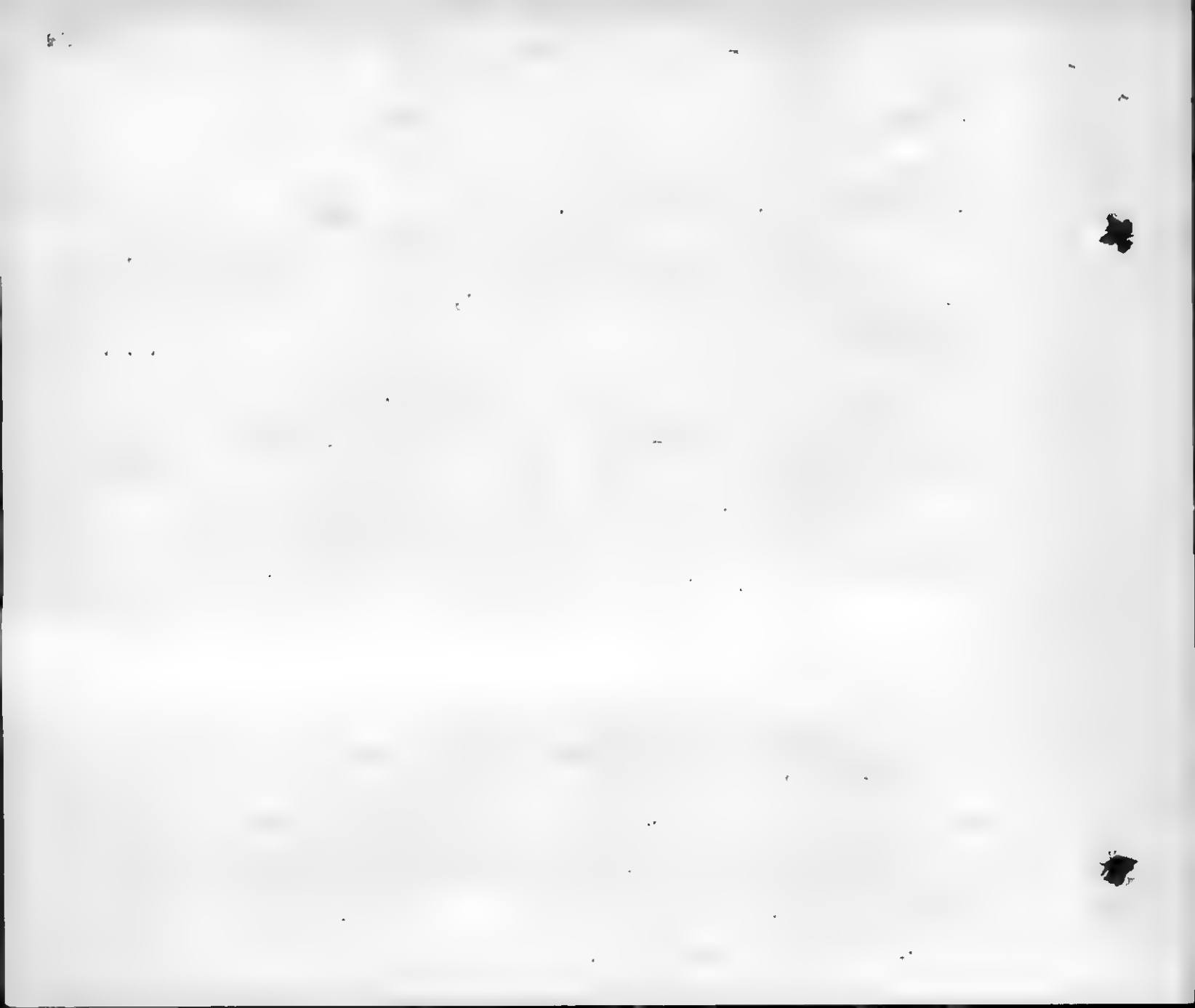
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>8 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Woodstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>54 Broad Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Lewis</b> Last <b>Wright</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1911</b>
9. AGE (In years last birthday) <b>47</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Wright</b>		14. MOTHER'S MAIDEN NAME <b>Louise M. Christy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>186-03-9045</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>754.5</b> DUE TO <b>massive hemorrhage and cardiac fibrillation - during surgery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>transventricular aortic valvulotomy</b> DUE TO (c) <b>calcific aortic stenosis + insufficiency</b>			INTERVAL BETWEEN ONSET AND DEATH <b>? Congenital</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. (CONDITION GIVEN IN PART I (a))			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 2, 1958</b> , to <b>November 10, 1958</b> , that I last saw the deceased alive on <b>November 10, 1958</b> , and that death occurred at <b>11:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. Perryman Collins</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>N. Perryman Collins, M. D.</b>		DATE SIGNED <b>11-10-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>14 Nov. 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook</b>		22d. LOCATION (City, town, or county) (state) <b>Wilmington, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Christina S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



12792

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>120 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>83 x 3</b> d. STREET ADDRESS <b>1410 W. 37th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patricia Ray Wright</b>			4. DATE OF DEATH Month Day Year <b>November 13 19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 1, 1954</b>		9. AGE (In years last birthday) <b>4 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Child)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Elmer Joseph Wright</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Mae Edwards</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMATION <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Valvular tumor</b> <b>180x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>11 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 16</b> , 19 <b>58</b> , to <b>November 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>November 13</b> , 19 <b>58</b> , and that death occurred at <b>3:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 11/13/58</b> <b>National Institutes of Health Bethesda 14, Maryland</b>					
ACTUAL SIGNATURE <b>G. Richard Lee</b>		M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>G. Richard Lee, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>14 NOV. 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Norfolk, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>4+MANOW ME</b>		24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12793

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Force</u> 75 x 3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Force</u> ✓			
c. LENGTH OF STAY IN 1b <u>125 days</u>				d. STREET ADDRESS <u>None</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chester (none) Zuchelli</u>			4. DATE OF DEATH Month Day Year <u>November 22, 1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1886</u>		9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>5 7</u>	IF UNDER 24 HRS. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>(Unknown) Zuchelli</u>				14. MOTHER'S MAIDEN NAME <u>Cecilia Briosi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Unavailable</u>		17. INFORMANT <u>The Medical Record Address</u> <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>191.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> (c) <u>Carcinoma of neck (epidermoid)</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>30 days</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <u>491X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 20, 1958</u> , to <u>November 22, 1958</u> , that I last saw the deceased alive on <u>November 22, 1958</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore L. Goodfriend</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Theodore L. Goodfriend, M. D.</u>				DATE SIGNED <u>11-22-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>11/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reynoldsville</u>		22d. LOCATION (City, town, or county) (State) <u>Jefferson County, Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>			

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of birth		6. Usual residence		7. Cause of death		8. Manner of death	
9. Name of physician		10. Name of funeral director		11. Name of informant		12. Signature of registrar	
13. Name of hospital		14. Name of attending physician		15. Name of medical examiner		16. Name of coroner	
17. Name of undertaker		18. Name of cemetery		19. Name of place of burial		20. Name of place of interment	
21. Name of place of death		22. Name of place of residence		23. Name of place of birth		24. Name of place of death	
25. Name of place of death		26. Name of place of residence		27. Name of place of birth		28. Name of place of death	
29. Name of place of death		30. Name of place of residence		31. Name of place of birth		32. Name of place of death	
33. Name of place of death		34. Name of place of residence		35. Name of place of birth		36. Name of place of death	
37. Name of place of death		38. Name of place of residence		39. Name of place of birth		40. Name of place of death	
41. Name of place of death		42. Name of place of residence		43. Name of place of birth		44. Name of place of death	
45. Name of place of death		46. Name of place of residence		47. Name of place of birth		48. Name of place of death	
49. Name of place of death		50. Name of place of residence		51. Name of place of birth		52. Name of place of death	
53. Name of place of death		54. Name of place of residence		55. Name of place of birth		56. Name of place of death	
57. Name of place of death		58. Name of place of residence		59. Name of place of birth		60. Name of place of death	
61. Name of place of death		62. Name of place of residence		63. Name of place of birth		64. Name of place of death	
65. Name of place of death		66. Name of place of residence		67. Name of place of birth		68. Name of place of death	
69. Name of place of death		70. Name of place of residence		71. Name of place of birth		72. Name of place of death	
73. Name of place of death		74. Name of place of residence		75. Name of place of birth		76. Name of place of death	
77. Name of place of death		78. Name of place of residence		79. Name of place of birth		80. Name of place of death	
81. Name of place of death		82. Name of place of residence		83. Name of place of birth		84. Name of place of death	
85. Name of place of death		86. Name of place of residence		87. Name of place of birth		88. Name of place of death	
89. Name of place of death		90. Name of place of residence		91. Name of place of birth		92. Name of place of death	
93. Name of place of death		94. Name of place of residence		95. Name of place of birth		96. Name of place of death	
97. Name of place of death		98. Name of place of residence		99. Name of place of birth		100. Name of place of death	